Prevention and Management of Sexually Transmitted Diseases in Men who Have Sex with Men:

A Toolkit for Clinicians

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First Edition
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Dear Colleagues,

Providing culturally sensitive health services to all is crucial for quality of care and for decreasing the burden of morbidity. Gay, lesbian, bisexual and transgender individuals are a significant population in Massachusetts. The 2000 Census identified 17,099 same sex households in our state. In addition, it is estimated nationally that at least 3%[1] of men report sexual activity with other men. Men who have sex with men (MSM) and other sexual minority patients are likely in the care of medical practices across the Commonwealth, whether or not recognized.

We acknowledge that all gay, lesbian, bisexual and transgender patients deserve a health care environment that is sensitive to needs and respects their lifestyles. This toolkit, however, specifically focuses on providing services to MSM because of recent epidemiologic trends in sexually transmitted diseases (STDs).

Increases in infectious syphilis and gonorrhea in MSM prompted the Massachusetts Department of Public Health, Division of STD Prevention, in collaboration with Fenway Community Health, to develop materials that would assist clinicians in supporting STD prevention efforts. As health care providers, we have the ability to slow the spread of STDs through appropriate screening, prompt treatment, and counseling. However, several societal, structural, and cultural challenges prevent us from delivering the best care possible to MSM. This toolkit was designed to help overcome barriers and provides information on recent STD trends and risk factors, on how to conduct a risk assessment, on STD screening recommended by the Centers for Disease Control and Prevention (CDC), on risk reduction counseling, on partner management strategies, and on useful resources and referrals. We are thankful for the many individuals and organizations that reviewed this document and provided insightful suggestions. Although some epidemiologic, reporting, partner services and resource information is specific to Massachusetts (note that some programs have adapted these sections to their states), the rest of the toolkit is relevant to clinicians throughout the U.S.

We hope that you will find this toolkit helpful for your practice, and that it will facilitate provision of care to MSM. We welcome your feedback and will be happy to participate in any CME activities that can help disseminate, and expand upon, the information contained in this toolkit.

Sincerely,

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- **Multiple sources, both in the U.S. and abroad, document an increase and/or a higher prevalence of STDs in MSM**

Key Epidemiologic Issues

In Massachusetts

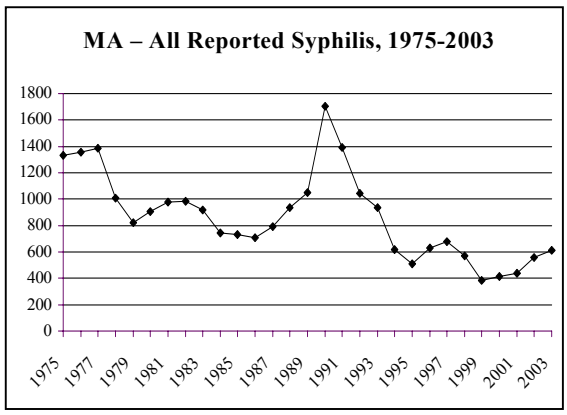
- **77% of all cases of infectious syphilis in 2003 were in MSM**
- **41% of MSM with infectious syphilis were human immunodeficiency virus (HIV) co-infected**
- **Cases of rectal gonorrhea in men have been increasing since 2001**
- **92% of all cases of quinolone-resistant *Neisseria gonorrhoeae* (QRNG) in 2003 were in MSM**

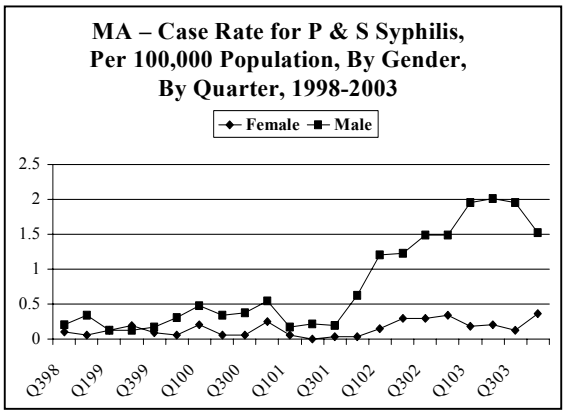
Section 1: Epidemiologic Trends of Sexually Transmitted Diseases (STDs) in Men who have Sex with Men (MSM)

Men who have sex with men (MSM) are at increased risk for sexually transmitted diseases (STDs), including human immunodeficiency virus (HIV), syphilis, gonorrhea, and hepatitis A and B. Numerous recent reports throughout the U.S. document increases in STDs in MSM that appear to be associated with unsafe sexual practices (1). Increases in STDs have also been reported in Europe and other countries (2).

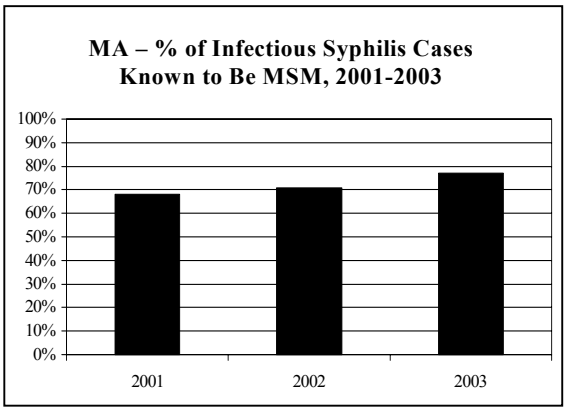
Syphilis

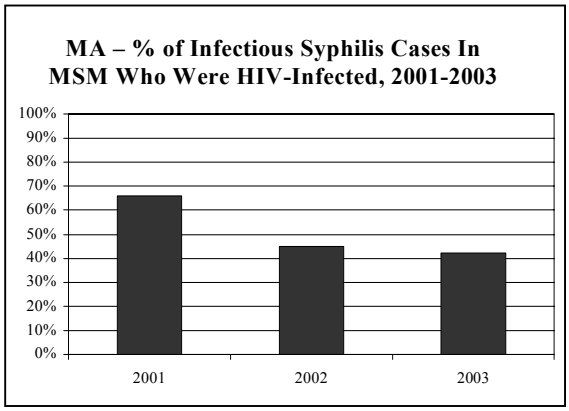
In Massachusetts, the number of primary and secondary (P&S) syphilis cases increased from 105 in 2001 to 257 in 2003, with higher rates occurring in men.





In the early 1980's, nearly 50% of cases of P&S syphilis occurred in MSM. Although overall reported numbers greatly increased in the early 1990's, less than 1% of all cases of P&S syphilis in 1990 occurred in MSM, reflecting the adoption of safer sexual behaviors. In 2003, although overall cases were lower than in 1990, more than 75% of the cases were detected in MSM. In addition, a large proportion of men with infectious syphilis (P&S and early latent) were HIV co-infected (3).



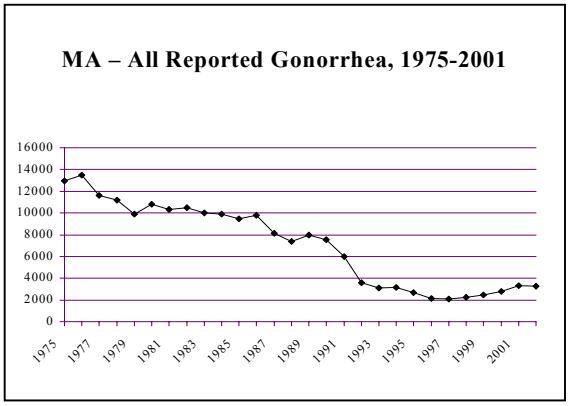


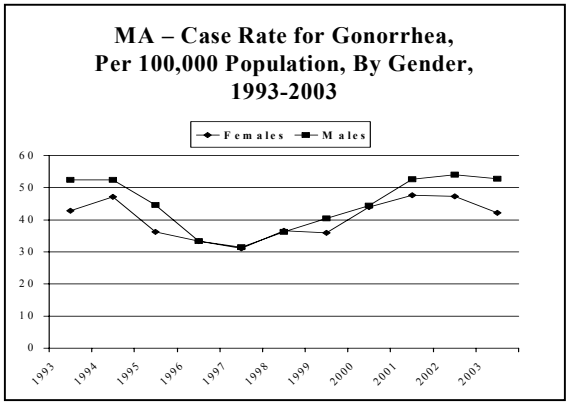
The increase in infectious syphilis in MSM has also been reported in other areas of the U.S., such as Southern California, San Francisco, Houston, Seattle, and New York City (4-10). The Centers for Disease Control and Prevention (CDC) estimates that over 40% of all cases of P&S syphilis in 2002 in the U.S. occurred in MSM (1).

The Massachusetts Division of STD Prevention (DSTDP), working with a number of partners, has engaged in a variety of public health interventions and outreach initiatives in the last two years in an effort to decrease the number of cases diagnosed in MSM.

Gonorrhea

Surveillance data strongly suggest an increase in gonorrhea morbidity in MSM. Overall in Massachusetts, rates of *Neisseria gonorrhoeae* infections started rising in 1997, with rates among men being higher than among women (3).





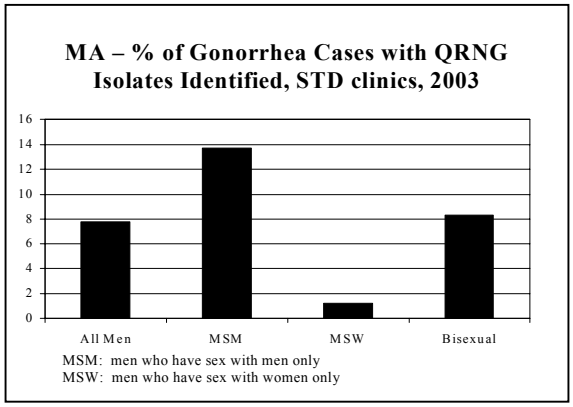
The reported morbidity data do not include information about the gender of sexual partners. However, reported cases of rectal gonorrhea in men (associated with unprotected anal intercourse) increased from 29 cases in 2001 to 106 in 2003, likely reflecting increasing morbidity in MSM (3).

Fenway Community Health (FCH), located in Boston, is the largest ambulatory facility caring for MSM in New England. FCH conducts annual surveillance of laboratory-confirmed cases of STDs. From 2001 to 2003, the number of cases of gonorrhea detected in MSM at the FCH increased from 47 to 142 (11). Although some of this increase can be attributed to changes in case ascertainment and enhanced screening and outreach, their findings are consistent with state and national trends.

The Gonococcal Isolate Surveillance Project (GISP), a collaborative among selected sexually transmitted disease clinics, was established in 1986 to monitor trends in antimicrobial susceptibilities of isolates of *Neisseria gonorrhoeae* in the U.S. Overall, the proportion of isolates from MSM increased from 4% in 1998 to 21% in 2002 (3).

In addition, test positivity for gonorrhea was higher in MSM who were HIV-infected, a finding also reported by New York City and Denver STD clinics (12,13). Of particular importance is the increasing number of cases of quinolone resistant *Neisseria gonorrhoeae* (QRNG). In Massachusetts, there were a total of 54 cases of QRNG in 2003, which represents 13.8% of all cases of culture-positive gonococcal isolates tested at the State Laboratory Institute (SLI). Most cases of QRNG (52/54) infection were identified in men and 92% of the male cases were in MSM (13). Data from the state funded STD clinics demonstrated that the proportion of QRNG was highest in MSM (15).

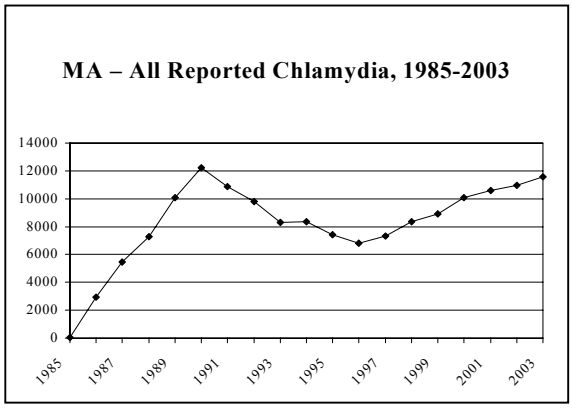
As of the end of November 2004, the proportion of gonorrhea isolates tested at the SLI that were QRNG was 24.3% (72/296). All QRNG were in MSM.

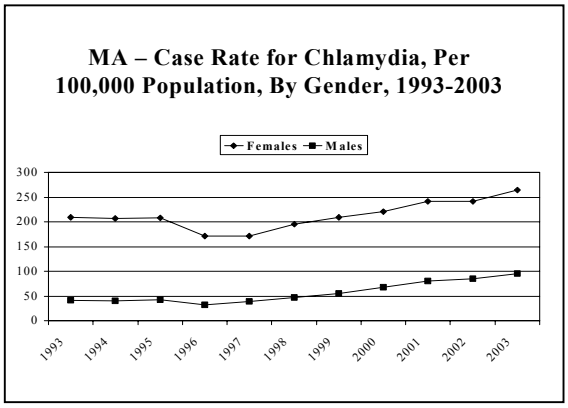


The GISP sites have also reported an increase in the proportion of *Neisseria gonorrhoeae* isolates that are resistant to quinolones (4). In their STD clinics, New York City reported a prevalence of QRNG ranging from 2% to 23% (16).

Chlamydia trachomatis

Although limited, data from Massachusetts suggest that *Chlamydia trachomatis* infection is not increasing in MSM and that prevalence is much lower than in other populations (women and men who have sex with women). Overall, *Chlamydia trachomatis* infection continues to be the most frequently reported bacterial STD. Although rates of infection are consistently higher among women because of screening efforts, rates have been increasing in men.





Routine chlamydia screening of males has not been as uniformly recommended by professional organizations as it has been for women. Given limited resources and little data on the cost-effectiveness of screening men, efforts have primarily been focused on testing women who bear the burden of complications resulting from untreated infection. Screening men has generally been reserved for certain settings, such as correctional facilities and school-based health centers. Few data are available to assess the prevalence of chlamydial infections in MSM. Testing pharyngeal and rectal sites is difficult because cultures, which are costly and often unavailable, are the only Food and Drug Administration (FDA) approved tests for these anatomical sites.

Data reported from selected clinical settings demonstrate that the prevalence of chlamydial infection varies, depending on the geography and presence/absence of symptoms. For instance, a population-based study in Philadelphia demonstrated that urethral chlamydia infections were detected in only one of 566 participants (prevalence 0.2%, 95% CI 0.004% to 1.0%), and rectal chlamydia infections were detected in two of 48 men (prevalence 4.2%, 95% CI 0.5% to 14.2%) by polymerase chain reaction (PCR) assay (17). In Seattle, the prevalence of anorectal chlamydial infections increased from 4.0% (1994-1996) to 7.6% (1997-1999) in MSM presenting at an STD clinic (18). In San Francisco, the prevalence of chlamydia infection in MSM presenting with non-gonococcal urethritis was 18%, similar to that of men who have sex with women (MSW) (20%). In addition, co-infection rates with gonococcal urethritis were higher in MSM (15.2%) than among MSW (8.2%) (19). A study conducted at the Massachusetts General Hospital demonstrated a 3.7% prevalence of urethral chlamydia in MSM compared with 4.7% among MSW, mostly in symptomatic males. Chlamydial co-infection rates among gonorrhea cases were higher among MSW than MSM (20). Finally, the STD Division conducted a chlamydia screening pilot study at Fenway Community Health in 2002. The findings underscored the low prevalence of urethral infections among high-risk asymptomatic men (1.1% or 2/186). Among men with urethritis, the prevalence was 10% (2/20).

Research has demonstrated that asymptomatic chlamydia urethritis may enhance the transmission of HIV infection. This makes a more compelling argument to screen asymptomatic HIV-infected men for chlamydia (21).

Viral hepatitis

Outbreaks of hepatitis A in MSM are a recurrent problem in many urban areas of the U.S. (22,23). Sexual practices involving oral-anal/oral-genital contact may facilitate fecal-oral exposure. In Massachusetts, such an outbreak in MSM occurred in 1997-1998.

The Advisory Committee on Immunization Practices (ACIP) of the CDC has recommended hepatitis A vaccination of MSM (24) since 1995. These recommendations are reiterated in the CDC 2002 STD Treatment Guidelines (25).

Since 1999, the incidence of hepatitis B has increased among males of more than 19 years of age (26). Among the most common risk factors reported by men with acute hepatitis B is having sex with men. CDC also recommends hepatitis B vaccination for MSM (25).

For more information see *Dear Colleague Letter, Pocket Card, Poster & Fact Sheet* in Section 12 or visit:
www.cdc.gov/ncidod/diseases/hepatitis/msm/

Human immunodeficiency virus (HIV)

Since the beginning of the AIDS epidemic, MSM have been at high risk of acquiring HIV infection. According to national data, 61% of persons living with human immunodeficiency virus or acquired immune deficiency syndrome (HIV/AIDS) and 33% of newly diagnosed HIV cases in 2002 had male-to-male sexual contact as the reported mode of transmission (27). In addition, CDC analyzed trends in HIV diagnoses in 29 states during 1999-2002 and demonstrated that the number of males with new HIV diagnoses increased 7.3%, while in MSM, the number with new HIV diagnoses increased 17.0%. The number of new HIV diagnoses did not increase significantly during 1999-2002 among females, persons exposed through heterosexual contact, or persons exposed through injection-drug use (28).

In Massachusetts, male-to-male sexual contact was reported in 36.4% of all AIDS cases reported up to 2002, but only 24.2% of cases reported in that year. There was a slight increase in the number of HIV infection cases reporting male-to-male sexual contact from 2001 (178) to 2002 (208) (3).

Multiple studies have demonstrated that the presence of an STD increases the risk for transmission and acquisition of HIV (29).

For more information see *HIV/AIDS, Hepatitis, STD and Substance Use Services and Resources* in Section 12 or visit:
www.mass.gov/dph/aids/services/hivresourceguide.pdf

Key Epidemiologic Issues

In Massachusetts

- **77% of all cases of infectious syphilis in 2003 were in MSM**
- **41% of MSM with infectious syphilis were HIV co-infected**
- **Cases of rectal gonorrhea in males have been increasing since 2001**
- **92% of all QRNG in 2003 were isolated from cases in MSM**

Human papilloma virus (HPV) infection and genital warts

HPV infection is likely the most common STD in the U.S. National estimates of the prevalence and incidence of HPV infection are based on various sources because HPV infection is not reportable in most states. The infection is largely sub-clinical and diagnostic methods vary. The CDC estimates that 20 million people are actively infected in the U.S., and that 5.5 million new cases occur each year. Estimates of the burden of HPV infection specifically in MSM are derived from only a few research studies.

Asymptomatic anal HPV infection has been detected in 30% to 48% of MSM who are not HIV-infected (30,31) and in up to 65% of HIV-infected MSM (32). A recent multicenter study among a group of MSM at high risk for STD/HIV demonstrated a mean anal HPV infection prevalence of 57%, with no significant geographic or age variation (33). There is an association between anal squamous intraepithelial lesions (SIL) and HPV (34). HIV-infected men are at higher risk of anal SIL (35).

Herpes simplex virus (HSV)

HSV infections are also very common in the U.S. The National Health and Nutrition Examination Survey III (NHANES III) conducted in 1999-2000 demonstrated an overall HSV type 2 seroprevalence of 17.6% in the U.S. population (36). HSV infections, both symptomatic and asymptomatic, have been associated with increased transmission and acquisition of HIV infection (37, 38, 39). Indeed, HIV-infected persons who are also HSV-2 co-infected are more likely to transmit HIV and HIV-uninfected men who are HSV-2 positive are more susceptible to HIV acquisition. HSV infections are more frequent in MSM compared with MSW (38). Early studies have reported prevalence of HSV as high as 80% to 95% in HIV-infected MSM (40,41,42).

Lymphogranuloma venereum (LGV)

A recent resurgence of LGV has been documented in Europe and was the subject of a recent Morbidity and Mortality Weekly Report (MMWR) article (43). Most cases reported in Europe were rectal LGV, with men presenting with gastrointestinal symptoms (e.g., bloody proctitis with a purulent or mucous anal discharge and constipation). Some men reported having sex with men in Europe, as well as in the U.S. Cases are now being reported in the U.S. The clinical manifestations of LGV proctocolitis can be similar to the initial presentation of inflammatory bowel disease. Clinicians should consider LGV in the differential diagnosis of the causes of proctocolitis in symptomatic MSM engaging in receptive rectal intercourse.

For more information see *MDPH LGV Clinical Advisory* at:
www.mass.gov/dph/cdc/std/divstd.htm

For the full MMWR report on *Lymphogranuloma Venereum Among Men Who Have Sex with Men --- Netherlands, 2003—2004* see Section 12 or visit:
www.cdc.gov/mmwr/preview/mmwrhtml/mm5342a2.htm

Key STD Issues

- **MSM are at increased risk for STDs**
- **Multiple sources, both in the U.S. and abroad, document an increase and/or a high prevalence of STDs in MSM**

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Section 2
Risk Taking Context
Summary Points

Key Behavioral Issues

- **Men who have sex with men (MSM) that use drugs and/or alcohol are at higher risk for engaging in sexual behaviors that may potentially expose them to human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs)**
- **Recreational drug use is prevalent among some MSM**
- **Some MSM report the need to get high in order to have pleasurable sex, believing that these substances increase sexual functioning**
- **Providers should speak with their patients about recreational drug use, both alone and in combination with sexual behavior, as these are possible high-risk interactions that can lead to HIV and/or STD exposure**

- **Club drugs are widely available at venues (bars, nightclubs, gay bath houses, circuit parties) that may be frequented by MSM**
- **MSM who frequent these venues are more likely to be exposed to drugs**
- **Use of these drugs is associated with high-risk sexual behavior**

- **MSM who use drugs often use them in combination**
- **Methamphetamine (crystal) use may be associated with increased libido and sexual encounters which may lead to abrasions and bleeding**
- **Nitrate inhalants (poppers) may increase susceptibility to HIV infection in men who engage in risky sexual behaviors**
- **Understanding contextual and psychosocial issues surrounding HIV and STD risk behaviors when using ecstasy, Viagra, poppers, and methamphetamine is an integral part of providing appropriate care**

- **Some MSM explore alternative venues for seeking sexual partners (Internet chat rooms, bathhouses, and/or public sex areas)**
- **These venues allow MSM to meet more easily for sex, are associated with riskier sexual behaviors, and may be a contributing factor to the rise in HIV infection and other STDs**
- **These venues facilitate anonymous sexual encounters, making public health interventions more difficult**
- **Only some MSM actually participate in these activities; as a result, only some MSM are at greater risk for HIV/STD infection**

Section 2: Risk Taking Context

The previous section presented information on the epidemiologic trends of sexually transmitted diseases (STDs) in men who have sex with men (MSM). This section describes some of the factors associated with increased sexual risk taking in some MSM. Medical providers can use this information as a tool for helping both themselves and relevant staff members understand the contextual issues surrounding human immunodeficiency virus (HIV) and STD risk behaviors.

Recreational drug and alcohol use and HIV/STD risk in MSM

Recreational drug and alcohol use is prevalent in MSM. MSM who use drugs and/or alcohol are at higher risk for engaging in sexual behaviors that may potentially expose them to HIV and other STDs. A number of studies have documented that the use of drugs and/or alcohol was associated with increased sexual risk taking in MSM.

A study of heavy alcohol and recreational drug use in 2,172 urban MSM found that both recreational drug (52%) and alcohol use (85%) were highly prevalent in urban MSM, and independently associated with risky sexual practices (1). Baseline data from the EXPLORE study (n=4,295), a behavioral intervention for high-risk MSM in six U.S. cities, showed that 48% and 55% of MSM across sites reported unprotected receptive or insertive anal sex in the six months previous to enrollment, respectively (2). Moreover, baseline data from this study also revealed that 26% of these MSM reported drinking alcohol at least three days per week, and 11% were heavy drinkers (i.e., they consumed at least four drinks per day or consumed an amount equal to six drinks per occasion). In this study, the most commonly used drugs were: marijuana (46%), nitrate inhalants (37%), methylene-dioxy-methamphetamine (MDMA or "ecstasy") (24%), cocaine (19%), and methamphetamine (13%). Ten percent of the men reported recent injection drug use. Drug and alcohol use was significantly associated with unprotected sex (2). In the Boston site (n=729 high-risk MSM), EXPLORE participants reported using the following substances at least once in the last six months: 9% heavy alcohol use, 43% marijuana use, 38% nitrate inhalant, 22% hallucinogen use, 16% cocaine use, 3% crack cocaine use, 1% heroin use, 7% amphetamine use, and 6% injection drug use. Furthermore, a cross-sectional study conducted in Boston with a cohort of 508 young (mean age=23.3) gay men found that individuals who had unprotected anal intercourse were more likely to have a drinking problem and drank more, compared with individuals who did not engage in unprotected anal intercourse. These patterns were also found for substance use in general (3).

Some MSM report the need to get high in order to have pleasurable sex, believing that substances increase sexual functioning. Drug use can also serve as a trigger to engage in riskier sex, and may alter coherent thinking patterns regarding sexual safety. **Providers should speak with their patients about recreational drug use, both alone and in combination with sexual behavior, as these are possible high-risk interactions that can lead to HIV and/or STD exposure.**

Key Behavioral Issues

- **MSM that use drugs and/or alcohol are at higher risk for engaging in sexual behaviors that may potentially expose them to HIV and other STDs**
- **Recreational drug use is prevalent in MSM**
- **Some MSM report the need to get high in order to have pleasurable sex, believing that these substances increase sexual functioning**
- **Providers should speak with their patients about recreational drug use, both alone and in combination with sexual behavior, as these are possible high-risk interactions that can lead to HIV and/or STD exposure**

Club drugs and MSM

Of particular concern is the availability of recreational drugs at MSM-frequented venues (so-called club drugs). These venues include bars, nightclubs, dance clubs, circuit parties, and high-risk sexual environments (e.g., gay bath houses). Club drugs include a wide variety of substances such as methamphetamine, nitrate inhalants, ketamine, and MDMA. All of these drugs have been shown to be associated with both injection drug use and risky sexual behavior (4). One study examined the use of methamphetamine, hallucinogen, and nitrate inhalant use over 4.5 years among 4,295 participants enrolled in project EXPLORE (5). The study found that, during baseline through follow-up, 28%, 38%, and 54% of participants reported methamphetamine, hallucinogen, and nitrate inhalant use, respectively. The use of each of these drugs was associated with risk of HIV seroconversion (methamphetamine: OR 2.1; nitrate inhalant use: OR 1.7; hallucinogen: OR 1.8) (5). Another study by the same authors conducted to evaluate drug use in MSM who attend circuit parties found that serodiscordant unprotected anal sex was more likely to occur among men who used methamphetamine, Viagra, and nitrate inhalants (5). This association of club drug use with the risk of HIV seroconversion underscores the need for providers to speak with their MSM patients about the regularity of attending these places and using drugs. These concerns are especially important because research has shown that young MSM report bars and/or dance clubs as their primary connection to the MSM community (6). If MSM are drawn to bars/night clubs to feel a sense of affinity to their community, their potential for exposure to illicit substances is elevated.

Commonly used recreational drugs

The following are examples of commonly used recreational drugs:

Trade Name	Commonly Used Street Equivalents
Methamphetamine, Amphetamine, Dexedrine	Crystal, crystal meth, speed, Tina
Cocaine	Blow, C, coke, flake, snow, stardust
MDMA (Methylene-Dioxy-Methamphetamine)	Ecstasy, Adam, E, essence, vitamin E, X, XTC
GHB (Gamma-Hydroxy-Butyrate)	GBH (grievous bodily harm), liquid-X
Heroin	Brown, China white, horse, junk, smack
Ketamine	K, ketalar, kit-kat, special K, vitamin K
Marijuana	Cannabis, dope, ganja, hooch, Marinol, Mary Jane, pot, THC
Amyl Nitrate, Butyl Nitrate, Isobutyl Nitrate	Poppers, amyl, ram, rush, volatile nitrate
Viagra, Sudenafil, Cialis	POKE

For a full list of common street terms, please see the Street Terms database that contains over 2,300 street terms that refer to specific drug types or drug activity: www.whitehousedrugpolicy.gov/streetterms

Key Behavioral Issues

- **Club drugs are widely available at venues (bars, nightclubs, gay bath houses, circuit parties) that may be frequented by MSM**
- **MSM who frequent these venues are more likely to be exposed to drugs**
- **Use of these drugs is associated with high-risk sexual behavior**

MDMA (ecstasy) use

MDMA (ecstasy) use has been shown to be associated with high-risk sexual behavior in MSM. A study of 733 MSM in New York City found that 13.7% reported using MDMA in the past six months, with a mean frequency of 6.24 times in that period (7). This study also found that MSM MDMA users reported more male sex partners, more one-night stands, and more visits to bars, clubs, sex clubs, or bathhouses. MDMA users also had a greater likelihood of engaging in unprotected anal sex.

A similar field study of MSM in Boston found that over 50% frequently used MDMA. These MSM also reported that MDMA use usually occurs in combination with other drugs, including ketamine, cocaine, methamphetamine, and Viagra (8). Moreover, the MSM in this study reported a high frequency of risky sexual behavior, in addition to reporting unprotected sex while using MDMA.

Viagra use

Viagra use has also been associated with high-risk sexual behavior in MSM. A study conducted in San Francisco looked at the prevalence of Viagra use in a community-recruited sample of 837 MSM (9). These researchers found that 32% reported having

ever used Viagra, while 21% had used it in the past six months. Recent Viagra use was significantly associated with illicit drug use and unprotected anal intercourse with a partner of unknown serostatus. Moreover, 36% of all Viagra users combined it with other drugs, including speed (23%), ecstasy (18%), ketamine (11%), and gamma-hydroxy-butyrate (GHB) (8%). Researchers are concerned that Viagra use may be a new contributing factor for high-risk sexual behavior and may be fueling HIV/STD transmission rates. In a study conducted in San Francisco, MSM who used Viagra in combination with other substances, like methamphetamine, were 6.1 times as likely as nonusers to test positive for syphilis (11,12). Primary care providers should assess the context and circumstance of their patients' Viagra use. For example, did another health care provider prescribe the Viagra to the patient or was it obtained on the street? Also, assess sporadic use along with other drugs at certain venues versus provider prescribed use for chronic erectile dysfunction, which may be associated with medical problems such as diabetes.

Nitrate inhalant (poppers) use

Many MSM report using poppers to make anal intercourse more pleasurable. However, MSM who use poppers before sex are more likely to engage in high-risk sexual behaviors which may potentially expose them to HIV and other STDs. One study found that men who reported popper use less than two hours before sex were more likely to have unsafe sex than those who had not (13). Animal studies have also shown that poppers may lower immune responses to infectious challenges many hours after use. This suggests that popper use enhances the likelihood of becoming infected with HIV and/or other STDs after sexual exposures. Moreover, another study of gay men who almost always used poppers during receptive anal intercourse showed that they were twice as likely to be HIV-infected as those who did not use poppers during receptive anal intercourse (14).

Methamphetamine (crystal) use

Methamphetamine use in MSM continues to grow and transmission of HIV and other STDs may be consequences of increased methamphetamine use (2). Research indicates that methamphetamine and related psychomotor stimulants can increase libido. Additionally, methamphetamine use may be associated with rougher sex, which may lead to bleeding and abrasions. The combination of increased libido and sexual risk behaviors could put MSM at greater risk for HIV infection. One study of sexual HIV risk in MSM found a strong association between methamphetamine use and high-risk sexual behavior (15).

At this time, the most effective treatments for methamphetamine addiction are cognitive behavioral interventions (2). These approaches are designed to help modify the patient's thinking, expectations, and behaviors and to increase skills in coping with various life stressors. These treatments, however, have not addressed HIV risk, nor have they addressed methamphetamine use among HIV-infected individuals.

Recognizing the signs of methamphetamine intoxication is important. Common indicators that someone is "tweaking" or using methamphetamine include: grinding teeth, obsessive picking of the face or body, hallucinations (auditory or visual), euphoria, extreme energy, insomnia for 2-3 days, dramatic weight loss, paranoia, and aggressive behavior. "Crashing" from methamphetamine often entails severe anergia (lack of energy) and massive anhedonia (sustained lack of motivation to perform normal tasks and inability to experience pleasure). The severity and duration of these symptoms vary depending on the amount of drug the patient used and the frequency of use.

For more information on the recognition and management of methamphetamine intoxication, and support groups, visit:
www.fenwayhealth.org/crystalmeth/home.htm
Also, see the *Fenway Community Health Crystal Methamphetamine and MDPH Crystal Methamphetamine Posters* in Section 12.

Key Behavioral Issues

- **MSM who use drugs often use them in combination**
- **Methamphetamine (crystal) use may be associated with increased libido and sexual encounters which may lead to abrasions and bleeding**
- **Nitrate inhalants (poppers) may increase susceptibility to HIV infection in men who engage in risky sexual behaviors**
- **Understanding contextual and psychosocial issues surrounding HIV and STD risk behaviors when using ecstasy, Viagra, poppers, and methamphetamine is an integral part of providing appropriate care**

Sexual risk venues

Some MSM explore alternative venues for seeking sexual partners, which may include Internet chat rooms, bathhouses, private sex parties, and/or public sex areas. These avenues allow MSM to meet more easily for sex, and may be a contributing factor to the rise in HIV infection and other STDs.

The Internet

Several Internet chat rooms are readily available for MSM to meet sexual partners. The advent of the Internet has made it significantly easier for MSM to find casual sex partners and researchers have found that Internet chat rooms may play a role in HIV and STD transmission. One study surveyed 2,934 MSM who frequently use the Internet as a means for meeting sexual partners on a general interest website called gay.com. Of the men surveyed, 82% reported meeting men online for sex and 60.5% said they had engaged in unprotected anal sex (16). Another study revealed that 22% of MSM who tested positive for syphilis had met their sexual partner via the Internet during the time

they were most likely infected (12). Furthermore, a study conducted at Fenway Community Health in Boston, found that 41% of STD patients, between 1992 to 2001, reported anonymous sex, and 25% had met sex partners on the Internet in the prior month (17).

Psychological factors, such as depression and loneliness, have been associated with high-risk behaviors, such as seeking sexual partners through the Internet and unprotected anal intercourse (2,10,11). Another concern with the use of the Internet for finding sex partners has to do with the frequency of anonymous sex. MSM who meet partners over the Internet are four times as likely to engage in anonymous sex than those who meet partners via other means (12). Having sex with partners one does not know poses problems in terms of partner notification of STDs.

The Internet provides MSM with the ease and convenience of meeting sexual partners, but it can also serve as a source of educational/awareness campaigns and sexual health service information. For example, several Internet chat rooms grant free memberships to HIV/AIDS and STD service organizations, allowing the organizations to conduct on-line prevention and outreach.

For more information on an MDPH online initiative see *Massachusetts State Guide for Working with Manhunt.net*:
www.ncsddc.org/peer-to-peer_res.htm

Bathhouses

Although there are no bathhouses in Massachusetts, some MSM travel outside the state for these venues. It is important to recognize that this occurs in a small subset of MSM. Less than 50 miles from Boston there are two bathhouses in Providence, RI. Bathhouses have been associated with the rise of HIV and STD transmission rates in MSM. In a study conducted at Fenway Community Health, researchers found that, in MSM STD patients seen between 1991 to 2001, 16% had been to a bathhouse or sex club in the prior month (17). In another study conducted by the Center for AIDS Prevention Studies, University of California at San Francisco (UCSF), researchers found that MSM who went to both public sex areas and bathhouses were most likely to report risky sexual behaviors (18).

Public sex areas

MSM who cruise public sex areas may be at risk for HIV and other STDs. Researchers at the Center for AIDS Prevention Studies, UCSF, conducted a prevalence study to see how many MSM were utilizing public sex areas as a means for soliciting sex with other men (19) and found that half of the MSM surveyed reported going to a sex venue (bathhouse and/or public sex area), of which 75% reported going to a public sex area. There are several public sex areas in Boston and the surrounding areas. MSM who frequent these places might be placing themselves at greater risk of exposure to HIV and other STDs.

Additional theories for high-risk behavior

The underlying reasons for the high-risk behaviors highlighted in this section are multiple. Other hypothesized reasons for the recent increase in high-risk behaviors in MSM include: "AIDS fatigue," where older MSM "tune out" HIV prevention messages; the belief that highly active antiretroviral therapy (HAART) eliminates the risk of HIV transmission; beliefs that HAART has made HIV a curable or minor disease; the perception of the relatively benign nature of STDs when compared to HIV; less communication about HIV; and decreased social support for safer sex.

Key Behavioral Issues

- **Some MSM explore alternative venues for seeking sexual partners (Internet chat rooms, bathhouses, private sex parties, and/or public sex areas)**
- **These venues allow MSM to meet more easily for sex, but are associated with riskier sexual behaviors and may be a contributing factor to the rise in HIV infection and other STDs**
- **These venues facilitate anonymous sexual encounters and can make public health interventions, such as partner notification, more difficult**
- **Only some MSM actually participate in these activities and as a result only some MSM are at greater risk for HIV/STD infection**

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Section 3
Understanding Sexual Orientation
Summary Points

Key Cultural Issues

- **Sexual identity, attraction, and behavior do not always align with each other; for example, some men who have sex with men (MSM) do not identify as gay or bisexual**
- **Understanding a patient's past and current sexual identity, attraction, and behavior allows the provider to build rapport with the patient and to situate care in the context of the patient's life and belief systems**
- **In order to obtain information that allows the best possible care for the patient, the patient must feel that the care provider is comfortable discussing sexuality and sexual behavior**

Key Clinical Issues

- **Maintain an open, non-judgmental attitude when discussing sexual partners**
- **Listen to how patients describe themselves and their partners and use their terminology**
- **Patients may, or may not, be emotionally involved with their sexual partners**
- **Patients with long-term partners may not be monogamous**

Section 3: Understanding Sexual Orientation

Understanding sexual orientation is important to providing culturally competent care to men who have sex with men (MSM). This section provides an overview of concepts and issues to consider when interacting with patients.

Dimensions of sexual orientation

Sexual orientation is a complex concept that changes over time and differs among cultures. Currently in the U.S., there are considered to be three distinct dimensions of sexual orientation: sexual attraction, sexual identity, and sexual behavior. These three dimensions often, but do not always, align. For example, a man may engage in sex with men only (behavior), feel attracted to men and women (attraction), and identify as straight (identity).

- **Attraction** refers to the sexual and/or emotional attraction one feels toward others. Attraction is often seen as being on a continuum, from exclusively heterosexual to exclusively homosexual, with the majority of people falling in between the two extremes. Some people feel equally attracted to men and women.
- **Sexual Identity** is how a person labels or defines her or himself, independent of sexual attraction or behavior. MSM may identify as gay, bisexual, queer, straight, or any other term that feels appropriate to the individual.
- **Sexual Behavior** refers to a person's actions, exclusive of sexual identity or attraction. The defining characteristic of MSM is that they have sex with men. However, they may also have sex with women or transgender individuals, and may identify in any number of ways.

When interacting with patients, it is important to stay open to the possibility that behavior, identity, and attraction may intersect in different ways for each person, may change over time, and may change multiple times. For the purposes of sexually transmitted disease (STD) prevention and management, the primary concern for providers is to determine the patient's sexual behavior and associated risks. However, understanding sexual identity in addition to behavior allows the provider to build rapport with the patient, as well as situate care in the context of the patient's life and belief systems. Providing support around identity issues can also help reduce risk behaviors.

In order to obtain information that allows the best possible care for the patient, it is important for the patient to feel that the provider is comfortable discussing sexuality and sexual behavior. To learn about a patient's identity and behavior, it is helpful to ask open-ended questions, listen to how the patient describes himself and his partners, and avoid making assumptions based on appearance, labels, gender of partners, or marital/relationship status. For example, a man who identifies as straight and is married to a woman may also have sex with men. A man who identifies as bisexual and is sexually attracted to men may currently be in a long-term monogamous relationship with a woman. The best care, therefore, can be delivered only when the provider takes the time to understand the patient's identity and behavior. For more information on communicating with patients, see Sections 4, 5, and 6.

Key Cultural Issues

- **Sexual identity, attraction, and behavior do not always align with each other; for example, some MSM do not identify as gay or bisexual**
- **Understanding a patient's past and current sexual identity, attraction, and behavior allows the provider to build rapport with the patient and to situate care in the context of the patient's life and belief systems**
- **In order to obtain information that allows the best possible care for the patient, the patient must feel that the care provider is comfortable discussing sexuality and sexual behavior**

Sexual and gender identity terms

Individuals may refer to themselves using a variety of sexual and gender identity terms; or they may prefer not to use any label at all. Some choose identities for political reasons or for social acceptance. Listen for how your patients describe themselves, and then use their terminology. Possible identity terms include: gay, bisexual, straight, MSM, heterosexual, queer, or same-gender loving (sgl). In addition, MSM may use terms specific to their culture or community. Gender identity, which is distinct from sexual identity, refers to a person's perception of his or her gender. Gender identity may change over time. Terms for gender identities include male, female, transgender, intersex, and queer. Some people may use other terms, or may feel they do not identify with any gender.

The following definitions are general, and do not apply to all people who self-identify using these terms. As described above, sexual attraction, sexual behavior, and sexual identity do not always align.

- **Gay man**: a man who is sexually and/or emotionally attracted primarily to men, has sexual and/or romantic relationships primarily with men, and feels that this is his main sexual identity. Gay can also be used as an umbrella term that includes lesbians and bisexual people, as in "gay community."
- **Bisexual man**: a man who is sexually and/or emotionally attracted to people of more than one gender, and has sexual and/or romantic relationships with people of more than one gender. Attraction can be equal for all genders, or stronger for one particular gender. Bisexual is sometimes abbreviated to "bi."
- **Straight man**: a man who is sexually and/or emotionally attracted primarily to women, has sexual and/or romantic relationships primarily with women, and feels that this is his main sexual identity.
- **Queer**: an increasingly popular term, especially among youth, that means many things to many people, but generally encompasses all gay, lesbian, bisexual, or transgender individuals, or anyone who doesn't conform to societal gender expectations. Queer can refer to sexual or gender identity. Because queer has historically been used as a derogatory term, it is best to avoid using it unless indicated otherwise by the patient.

- **Transgender**: people who are born male or female, but whose primary identity is with another gender. However, a transgendered person may fall anywhere along the gender spectrum. Transgendered individuals may express their identity by undergoing hormonal and/or surgical procedures to establish physical and emotional gender congruence, or they may dress and behave in ways considered more congruent with one gender. "Cross-dressing," however, does not automatically imply that a person is transgendered. Some individuals dress in garments associated with the other gender for entertainment purposes or to experience erotic sensations, but not because they identify as another gender.
- **Intersex**: individuals who biologically are born with or acquire physical characteristics of both male and female sexes, which may be due to chromosomal and/or hormonal abnormalities.

MSM relationship terms and insights

As with all people, relationships in MSM take a variety of forms and can change over time. Some MSM are in long-term monogamous relationships with a primary partner, some are in open relationships with a primary partner (meaning they agree to have additional sexual partners), others are dating or have casual relationships. Non-primary sexual partners might include friends, casual partners met through friends or in social settings, or anonymous partners, such as those met on the Internet. Some MSM remain abstinent for lengths of time. Because a patient's relationship status can change over time, it is always a good idea to inquire. In addition, patients with primary partners may wish to include them in their health care decisions.

It is important not to assume that a patient is monogamous with his long-term partner, or that all sexual partners are also involved with the patient emotionally. Maintain an open, non-judgmental attitude when discussing relationships and sexual partners.

MSM who are involved in a primary relationship with another man may use any of the following terms to describe their primary partner(s): lover, significant other, companion, partner, life partner, friend, or roommate. They may also say husband or spouse, whether or not they are legally wed. Listen for how the patient describes his partner(s) and, if you feel comfortable, use that term. If the patient does not give any clues, the term "partner" is usually an acceptable way to start. Terms used for casual or anonymous sexual partners include: lover, sex partner, trick, or friend.

The popularity and acceptability of terms differ by individual and can change over time. If you are unsure about the choice of language, ask the patient if he prefers a different term.

Key Clinical Issues

- **Maintain an open, non-judgmental attitude when discussing sexual partners**
- **Listen to how patients describe themselves and their partners and use their terminology**
- **Patients may, or may not, be emotionally involved with their sexual partners**
- **Patients with long-term partners may not be monogamous**

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Section 4
Culture, Community, and Identity: Implications for Care
Summary Points

Key Cultural Issues

- **Men who have sex with men (MSM) who are not gay-identified or are less involved in the lesbian, gay, bisexual, transgender (LGBT) community may benefit from basic sexually transmitted disease (STD) risk and prevention education**
- **MSM who are more gay-identified may be more educated about STDs, but also may view STDs as normative and not see their behavior as high-risk**
- **MSM, especially MSM of color, may identify more as a member of an ethnic or racial group than as a sexual minority, and may not identify as gay or bisexual at all**

Key Clinical Issues

- **Given that some MSM identify as straight, it is important to always ask open-ended questions in a behavioral risk assessment, to not make assumptions about the sex of the patient's sex partners, and to provide education and messages about safer sex with men and women**
- **It may take time to build trust and rapport so that the patient feels comfortable disclosing his sexual behavior with his provider**
- **Some MSM of color may not want to use services that are specifically for gay men, as they may not identify as gay or may not see the services as congruent with their racial or ethnic identity. They may also feel uncomfortable accessing services in their own community for fear of being stigmatized as gay**
- **Since every community is different, providers will benefit from becoming familiar with the sexual and gender norms within the communities they serve**

Section 4: Culture, Community, and Identity: Implications for Care

To provide optimal sexually transmitted disease (STD) prevention and treatment for men who have sex with men (MSM), it is important to gain a deeper understanding of how community, culture, and sexual identity interact to influence sexual behaviors and beliefs. This section provides information on these issues as well as practical advice to overcome potential barriers to care. Demographic factors, such as age, socioeconomic status, geographical location, place of birth, and immigration status, are not covered in this section, but should also be considered as important influences on MSM sexual health behaviors and beliefs.

Lesbian, gay, bisexual, transgender (LGBT) community

Since the evolution of the gay rights movement in the late 1960s, MSM have had an increasing array of support systems and entertainment venues that provide comfort and validation as a sexual minority. Today in New England there are hundreds of social events, bars and clubs, support groups, legal organizations, and religious groups for gay men and other LGBT individuals. Those who are involved in one or more of these groups and events are often seen as being connected to the "LGBT community." MSM display a wide range of involvement with the LGBT community, from no involvement at all, to complete immersion in both work and social life. The level of involvement can change over time and often depends on an individual's age, relationship status, place of residence, degree of being "out" to friends and family, and degree of identification as gay or bisexual.

Involvement in the LGBT community can influence men's knowledge of and beliefs about STDs. Men who attend LGBT community events, for example, tend to have greater exposure to prevention messages and health education targeted to MSM. They may be more aware of the signs of symptoms of STDs, the reasons to be screened regularly, and the importance of condom use. Some men who are knowledgeable about STD testing and treatment may view STDs as an acceptable consequence of taking sexual risks. These men's feelings about acceptable risks may differ from those of their providers. Remaining non-judgmental and using client-centered, stage-based behavioral counseling may assist in reducing risk behaviors, if deemed necessary (see Section 9: Behavioral Counseling).

MSM who are married, identify as straight, do not disclose their sexual behavior, and/or live in rural areas, can have little or no connection to the LGBT community. As a result, these men may have less exposure to STD prevention education and messages or may believe these messages are not relevant to them. Increased access to the Internet may be changing this somewhat, given the growing number of gay men's health websites, as well as on-line dating services that provide health information. In addition, non-urban MSM may intermittently come into the city to meet partners, and may have exposure to messages this way. Nonetheless, these men may benefit from basic information on STD risk and prevention. Keep in mind that men who are not involved in the LGBT

community or are not gay-identified may take longer to share sexual behavior information with their providers, and may not feel STD prevention is relevant to them. (See Sections 5, 6, and 9 for more information on communicating with patients about sexual risk and behaviors.)

Key Cultural Issues

- **MSM who are not gay-identified or are less involved in the LGBT community may benefit from basic STD risk and prevention education**
- **MSM who are more gay-identified may be more educated about STDs, but also may view STDs as normative and not see their behavior as high risk**
- **MSM, especially MSM of color, may identify more as a member of an ethnic or racial group than as a sexual minority, and may not identify as gay or bisexual at all**

Cultural identity

Many MSM, at some point in their lives, find they must cope with the complex interactions between their sexual and cultural identities. Culture here refers not only to the values, beliefs, and traditions of racial and ethnic groups, but also to those of religious groups, national heritage groups, regional communities, etc. The challenge of embracing both gay and cultural identity can be particularly difficult for those from communities that view homosexual behavior as conflicting with certain deeply held beliefs, such as:

- Conformity to specified gender roles, with men being seen as the primary providers and protectors
- Continuation of the family line through reproduction
- Strong cultural or religious convictions that deeply disapprove of homosexuality and/or deny its existence

Although some communities hold social biases against homosexuality, this does not always mean that an individual MSM will be rejected or discriminated against by his family and community. Many communities continue to embrace individual gay and bisexual members, or at least quietly accept homosexual behavior as long as the issue is never discussed. In some communities, it is acceptable for a man to have sex with men as long as he continues to follow his culture's male gender role both sexually (as the insertive partner in anal sex) and socially.

Since every community is different, providers will benefit from becoming familiar with the sexual and gender norms within the communities they serve. This will provide a context for better understanding patients, but does not substitute for getting to know the patient and the patient's situation on an individual level. It may take time before a patient feels safe enough to disclose his sexual behavior to his provider, and so it is important to focus on building trust and rapport.

Sexual identity in MSM of color

MSM from any racial or ethnic group may identify as gay, bisexual, or straight/heterosexual. Their identity as gay or straight can sometimes depend on whom they are interacting with (e.g., they may be "out" to friends and family, but not to church congregants or colleagues). MSM of color may identify more as a member of their ethnic or racial group than as a sexual minority, may choose a dual identity (e.g., Latino gay man), or may not identify as gay or bisexual at all. In fact, although many MSM from racial/ethnic minority groups identify as gay or bisexual, research suggests that MSM of color are less likely to identify as gay than white MSM, and that African American MSM are the most likely to identify as heterosexual. There are several possible reasons for this:

- Gay identity is seen by some as a white, middle-class phenomenon
- Gay identity is seen by some as a rejection of family, religious values, and culture
- Some communities hold strong biases against homosexuality and bisexuality
- Some cultures view discussion of sex and sexuality as taboo
- Some cultures do not have any language for, or a conceptualization of sexual identity
- Some people of color have been marginalized or discriminated against by a mostly white gay community

Given that some MSM identify as heterosexual, it is important to always ask open-ended, non-judgmental questions in a behavioral risk assessment and not to make assumptions about the gender of the patient's sex partners.

In making referrals, keep in mind that some MSM of color may not want to use services that are specifically for gay men, as they may not identify as gay or see the services as congruent with their racial or ethnic identity. They may also feel uncomfortable accessing services in their own community for fear of being stigmatized as gay. Fortunately there are services and support groups available for MSM of different racial and ethnic groups in Massachusetts that can be of help.

For more information about these support services see *HIV/AIDS, Hepatitis, STD and Substance Use Services and Resources* in Section 12 or visit: www.mass.gov/dph/aids/services/hivresourceguide.pdf

Finally, MSM of color, particularly those who identify as heterosexual, may underestimate their risk for STDs and human immunodeficiency virus (HIV) and may pay less attention to safer sex public health messages that are targeted to gay (ostensibly white) men. It may be helpful to have safer sex brochures and pamphlets in your office/clinic, therefore, that reflect the race/ethnicities of your patient population, that address sex with men and women, and that do not exclusively use gay and bisexual terminology.

Living on the "down low"

For a variety of reasons (as listed above), some MSM do not disclose their sexual behavior within their communities. The popular phrase "on the down low" refers to men who have public emotional and sexual relationships with women while also having undisclosed relations with men. Their female partners may be casual encounters, wives, girlfriends, and/or the mothers of their children. Living on the "down low", usually used in reference to African American men, is not a new or exclusively African American phenomenon, but rather a new name for a long-standing practice among all cultural groups.

MSM who have female partners, but do not disclose their behavior to their partners, may not use protection consistently with men or women because they do not want to raise suspicions by carrying and using condoms. Again, remaining non-judgmental, providing factual information, and using client-centered, stage-based behavioral counseling may assist in reducing risk behaviors (see Section 9: Behavioral Counseling).

In addition, for men who have sex with both men and women, it is important to include prevention education and counseling that addresses sexual behavior with women as well as men. Many HIV/STD prevention interventions and educational materials target gay men only, ignoring men who have sex with men and women. This can give the impression that having sex with female partners is risk free, or that the only risk with female partners is transmitting but not acquiring disease. It is important, then, to be prepared to give HIV/STD prevention education that focuses on HIV/STD risk and safer sex practices with both men and women.

Key Cultural Issues

- **Given that some MSM identify as straight, it is important to always ask open-ended questions in a behavioral risk assessment, to not make assumptions about the sex of the patient's sex partners, and to provide education and messages about safer sex with men and women**
- **It may take time to build trust and rapport so that the patient feels comfortable disclosing his sexual behavior with his provider**
- **Some MSM of color may not want to use services that are specifically for gay men, as they may not identify as gay or see the services as congruent with their racial or ethnic identity. They may also feel uncomfortable accessing services in their own community for fear of being stigmatized as gay**
- **Since every community is different, providers will benefit from becoming familiar with the sexual and gender norms within the communities they serve**

Experiences of discrimination

Negative attitudes and social stigmas still exist against homosexuality and bisexuality in most communities in the U.S. Some men perceived as gay or bisexual experience discrimination based on their sexual orientation, and may suffer psychosocial stressors related to that discrimination. Experiences of discrimination are not universal in MSM, however, and the degree of stress experienced as a result of discriminatory acts can vary considerably.

Discrimination can affect MSM economically—for example, a gay man may be fired because of his sexual orientation, or a gay couple may be refused a lease on a one-bedroom apartment. Discrimination may also take the form of verbal, sexual, or physical abuse, sometimes in the form of hate crimes. Finally, not all acts of discrimination are committed on the individual level. Many social customs and institutions assume heterosexuality or exclude people who have same-sex relationships.

For MSM of color, experiences of heterosexism can be exacerbated by racial/ethnic discrimination, and vice versa. Racism, sexual prejudice, and low socioeconomic status can interact to influence a patient's access to, and trust in, the health care system. If a patient lacks trust in his provider, he may be less willing to disclose risk behavior, get tested for HIV infection and STDs, or follow medication recommendations. In the clinical setting, cultural sensitivity with regard to race/ethnicity is as important as sensitivity about sexual behavior.

Prolonged exposure to discrimination can lead to poor mental and physical health outcomes. Studies have found that chronic exposure to discrimination is associated with psychological distress, such as low self-esteem, social isolation, guilt, relationship instability, and suicide. When homophobia becomes internalized, it can lead to a reduction in health-promoting behaviors and willingness to access social support. It can also lead to a reduced ability to negotiate safer sex. Many MSM seek out social support from friends and/or LGBT groups to help prevent and heal the effects of discrimination.

Although discriminatory experiences and psychological distress resulting from those experiences are far from universal in MSM, it may be helpful to consider the following questions when screening and treating for STDs:

- Will the diagnosis of an STD intensify a patient's feelings of shame and guilt?
- Would the patient benefit from a mental health or support group referral?
- Will feelings of shame affect his ability to follow a treatment protocol or tell his partner(s)?
- How might he explain a new STD to a wife, husband, or other steady partner?
- Will previous experiences of discrimination in the health care system lead the patient to withhold information from his provider?
- Does the patient have any social support for reinforcing prevention messages?

Negotiating treatment and disease self-management with MSM

Negotiating treatment and disease management with MSM first involves an acknowledgment by the patient and the provider that there may be lack of congruency between their health belief systems. An MSM patient, for example, may have different notions of what "safer sex" means and may engage in sexual activities that are unfamiliar to you. Because patients are less likely to adhere to interventions that are not congruent with their own health belief systems, it is important to remain open and non-judgmental when interacting with all patients, and provide counseling centered on the patient's circumstances and active participation.

Examples of how miscommunication and misunderstanding play out:

MSM

"I didn't agree with what the doctor said about oral sex being a risky activity."
"He/She didn't listen to my understanding of what it is to have HIV and get another STD."
"I'm going to have sex without condoms, no matter what he/she says."

Provider

"The patient didn't do what I asked him to."
"This patient won't benefit from the information I have or treatment because he isn't willing to change his behavior."
"The patient doesn't understand how to keep himself safe!"

The provider can often reach a compromise with the patient's views and/or respect the patients' belief system. Treatment negotiation can then focus on explaining:

- Why specific risk reduction activities are recommended (their effectiveness, ease of use, etc.)
- The importance of taking and monitoring medication use, and the impact of not treating an infection at the earliest time possible
- The need to identify partners, so they can be treated, to protect their health, and to limit further dissemination of the infection.

These issues will be further explored in Section 9: Behavioral counseling.

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Section 5
Creating a Safe and Welcoming Practice
Summary Points

Key Office Issues

- **Do your intake forms use inclusive language?**
- **Do the waiting and exam rooms have literature and visuals sensitive to sexual diversity?**
- **Has the staff been trained in health issues specific to men who have sex with men (MSM)?**
- **Do your office policies prohibit discrimination, including against MSM and other sexual minorities?**

Key Communication Issues

- **Never assume a patient is heterosexual or homosexual**
- **Use gender-neutral language when talking about sexual or emotional partners**
- **Use the same language as your patient when talking about sexual behavior and identity**
- **Be sensitive to patient concerns about confidentiality**

Section 5: Creating a Safe and Welcoming Practice

An important step in promoting the sexual health of men who have sex with men (MSM) is to ensure that your office or clinic is welcoming to all patients, including lesbian, gay, bisexual, and transgender (LGBT) individuals. Doing so can build trust, alleviate patient concerns about discrimination, and signal that it is safe to discuss sexual behavior and health needs related to sexually transmitted diseases (STDs). The following section consists of several recommendations and guidelines that can help you create a more welcoming environment. Implementing even just a few of these suggestions can go a long way toward enhancing the comfort of your patients, leading to better quality of health care overall.

Anticipate concerns about discrimination

The importance of creating a safe environment is supported by several research studies that have documented anti-gay discrimination in health care settings and negative attitudes towards gay and lesbian patients by their providers. For example, a study by Matthews et al. showed that nearly 40% of physician respondents admitted feeling discomfort with providing medical care to gay patients. In a 1994 national survey of LGBT physicians and medical students, 88% of respondents reported hearing their colleagues disparage lesbian, gay, or bisexual patients. Acceptance and support of sexual minorities may be less pronounced in local providers, however. A 1997 exploratory study in Boston found that only 6% of gay men felt that their care was worse as a result of their sexual orientation; however those interviewed were predominantly white, in their 30's, and openly gay, and may not represent the experiences of other MSM.

Policies, standards, and office culture

Because all members of a health care team, including administrative and medical assistant staff, are essential to providing quality care to clients, implementing system-wide policies, training, and guidelines in support of culturally-competent care for MSM will not only improve the quality of care, but may relieve anxiety and confusion among staff who may not feel prepared to serve MSM clients. These standards can be integrated into an overall strategy of non-discriminatory practices and cultural sensitivity in your office, clinic, or hospital.

<u>What to consider</u>

- Implement a policy that prohibits discrimination in service delivery to all patients, including LGBT clients (See *Examples of Non-Discrimination Statements* in Section 12).
- Implement a policy that prohibits discrimination in the hiring of LGBT staff and that encourages recruitment of "out" providers (See *Examples of Non-Discrimination Statements* in Section 12).

- Provide staff-wide training in:
    - Culturally-competent language and interactions
    - MSM-specific health problems and treatment issues
    - How and when to refer patients to LGBT-friendly providers.
- Distribute a referral list to staff of LGBT-friendly community resources and organizations.
- Reach out directly to LGBT clients by advertising in gay media or joining a referral service or directory of LGBT-friendly providers.
- Bring together clients and staff to form an advisory committee on LGBT issues.

Office and clinic space

Strategically placing LGBT-friendly visual cues in waiting and exam rooms will help set a welcoming tone, and is the first step in building trust.

What to consider

- Distribute brochures that are specific to MSM health issues (such as hepatitis A and B, syphilis, HIV), and that are written for MSM clients.
- Produce your own educational materials specific to MSM health issues.
- Post signs announcing that your practice provides equal service regardless of age, race, sex, sexual orientation, gender identity, religion, language, or disability.
- Display posters and pamphlets that have LGBT-friendly symbols and messages, such as images of same-sex couples, rainbow flags, and pink triangles.
- Include advertisements of events relevant to MSM, such as National Coming Out Day, Gay Pride, etc.
- Provide culturally appropriate, LGBT-focused reading material in the waiting room, such as Bay Windows or In Newsweekly (local weekly newspapers), or national magazines, such as the Advocate.
- Put ads in local papers publicizing your commitment to providing quality health care to LGBT patients.

Key Office Issues

- **Do your intake forms use inclusive language?**
- **Do the waiting and exam rooms have literature and visuals sensitive to sexual diversity?**
- **Has the staff been trained in MSM-specific health issues?**
- **Do your office policies prohibit discrimination against MSM and other sexual minorities?**

Intake and health history forms

Since intake forms are one of the first encounters patients have with a clinic, they serve as another way to help patients feel welcome and safe.

What to consider

- Use inclusive language throughout the forms. For example:
  - Use gender neutral terms, such as partner/spouse instead of husband/wife.
  - Include transgender and intersex as gender options.
  - Replace the category "marital status" with "relationship status," and include terms such as "partnered" in addition to "married." Consider adding "multiple partners" as an option.
  - Now that same-sex marriage in Massachusetts is legal, inquire about the gender of the spouse or partners, and whether they are married.
  - Allow for same-gender parents in questions about families.
- Be clear about confidentiality—include who will read this information, how it will be used, and whether it will be put in the patient's medical record.
- Offer the right to decline answering a question.
- Review all intake and health history forms for any questions where the wording assumes heterosexuality.
- Consider offering patients a "Bill of Rights" which describes in writing your practice's commitment to non-discrimination, confidentiality, and culturally-sensitive health care.

Helpful websites:

Materials and policies:

- www.glbthealth.org
- www.lgbthealth.net
- www.cdc.gov/ncidod/diseases/hepatitis/msm/

Media subscriptions:

- www.advocate.com (National)
- www.baywindows.com (New England)
- www.innewsweekly.com (New England)

On-line LGBT Provider listings:

- www.glbthealth.org/resourceguide.html
- www.gayhealth.com
- www.glma.org
- www.bizone.org

The patient interview

Provider knowledge of sexual behavior is critical for delivering appropriate care, particularly with regard to STDs and human immunodeficiency virus (HIV). Not surprisingly, however, many patients of all sexual orientations initially feel uncomfortable sharing their sexual history with their providers, or do not recognize the importance of discussing sexual behavior. LGBT individuals in particular may be reluctant to discuss sexual behavior because of worries about eliciting a negative reaction or substandard care. During the patient interview, there are several ways to build trust so that patients feel comfortable disclosing all relevant information, and continue to feel cared for once they disclose. Clinician communication style has been shown to be the most important factor in patient willingness to disclose their sexual orientation.

<u>What to consider</u>

- Be aware of your verbal and body language: try to be as open and non-judgmental as possible.
- As with intake forms, use gender-neutral language when inquiring about partner relationships and avoid making assumptions about family and relationships.
- Use the same language as your patient when talking about sexual behavior and identity. If you are not sure what terminology to use, ask the patient what he prefers.
- If the patient is in a primary relationship, offer to include his partner in medical decision-making.
- Keep in mind that any of your male patients might have sexual relationships with other men and/or identify as gay or bisexual. Don't make assumptions about sexual behavior, even if the patient is married to a woman.
- Examine your own beliefs about homosexuality, same-gender partnerships, etc. Do any personal biases get in the way of your delivery of care? Do you assume all your patients are heterosexual? What modifications are indicated in your communication and treatment approach with the patient?

It may take time to feel completely comfortable in communicating with patients about sexual health and behaviors. However, it is not necessary to have all the answers right away. In a focus group study with bisexual men in the Boston area, for example, participants distinguished "good providers" from "bad providers" by their "willingness to listen to their patient and to learn about bisexuality, rather than upon any expectation that they already had knowledge about the issue." You will likely experience some awkward moments and miscommunications. It is okay to apologize to the patient and explain that you are still learning and growing in understanding.

For more detailed information, see Section 6: Conducting a Behavioral Risk Assessment.

Key Communication Issues

- **Never assume a patient is heterosexual or homosexual**
- **Use gender-neutral language when talking about sexual or emotional partners**
- **Use the same language as your patient when talking about sexual behavior and identity**
- **Be sensitive to patient concerns about confidentiality**

Confidentiality and medical records

Some MSM may be more comfortable discussing their sexuality if they know that it will not be detailed in their medical record. Tell the patient what you believe is clinically relevant to include in the record for continuity of care and good medical practice, who has access to his medical records, and what the privacy protections are for medical records in your practice. Make sure to obtain the patient's permission before documenting anything.

The Health Insurance Portability and Accountability Act (HIPAA) standards for protecting the privacy of individual identifiable health information (privacy rule) cover medical record information. All patients should receive information about under which circumstances the information will be released and must be made aware of their right to confidentiality.

Confidentiality issues related to partner notification of those diagnosed with a reportable STD can be found in Section 10: Reporting and Partner Services.

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Section 6
Conducting a Behavioral Risk Assessment
Summary Points

Key Behavioral Risk Assessment Issues

- **Risk assessments should be integrated with each new patient visit and updated on a regular basis as the patient's circumstances and behaviors might change over time**
- **Risk assessments should include sexual behavior, as well as substance and alcohol use**
- **Prepare the patient for questions to come – qualify the discussion of sexual health by underscoring that the interview is part of the routine care process**
- **Emphasize both the importance of confidentiality and wanting to provide quality care**

Key Counseling Issues

- **Make no assumptions about the behaviors of patients**
- **Make risk assessment routine for all patients**

Section 6: Conducting a Behavioral Risk Assessment

It is likely that most primary care practices will have patients who are men who have sex with men (MSM); therefore, medical providers may be able to play an important role in human immunodeficiency virus (HIV) and sexually transmitted disease (STD) prevention in this population. As stated in previous sections, MSM continue to be among the groups with the highest HIV prevalence and incidence in the U.S., and recent trends documenting a rise in STDs in MSM highlight the continued need for conducting behavioral risk assessments within primary care practices. Moreover, MSM are at greater risk for specific health issues, such as substance abuse, suicide, depression, and possibly anal cancer than heterosexuals from similar demographic groups. However, MSM may be less likely than their heterosexual counterparts to receive adequate assessment, treatment, and prevention of health problems. Helping MSM in altering high-risk behaviors can decrease the risks posed by these major concerns.

Healthy People 2010 (1) recognized that health promotion is largely dependent on changing individual health-risk behaviors, and that it was primarily through assessing and altering high-risk behaviors that disease morbidity and mortality could be reduced. Within the primary care context, medical providers have the opportunity to employ primary prevention of HIV and other STDs by assessing their patients' risk behavior. Social and cultural factors, as well as mental health, substance abuse and patient-specific risk behaviors play an important role in a risk assessment tailored to MSM. This section of the toolkit offers suggestions for types of questions to include in a MSM behavioral risk assessment and details how to chart a patient's sexual risk assessment. Using a stage of change (precontemplative, contemplative, ready for action, action, or maintenance) model approach (2) to conduct counseling, assessing the barriers that might be present, and determining the appropriate methods to address them are discussed in Section 9.

Questions to include in an MSM behavioral risk assessment

Speaking with patients about their sexual behavior might make some providers feel uncomfortable and/or embarrassed. The Mountain-Plains Regional AIDS Education Training Center developed an HIV sourcebook for the primary care provider (3) that provides a useful model for approaching sexual risk assessment. The Gay and Lesbian Medical Association (4) modified this model specifically to address issues concerning MSM. For the purpose of this toolkit, we have further modified the version published by the GLMA. Remember that it's often the clinician's own perception that patients may be shocked by questions about drug or sexual activity. In fact, most patients welcome them. In addition to sexual and substance use, other health-related issues such as sexual dysfunction, and domestic violence should be assessed.

Key Behavioral Risk Assessment Issues

- **Risk assessments should be integrated with each new patient visit and updated on a regular basis as the patient's circumstances and behaviors might change over time**
- **Risk assessments should include sexual behavior, as well as substance and alcohol use**
- **Prepare the patient for questions to come – qualify the discussion of sexual health by underscoring that the interview is part of the routine care process. Emphasize both the importance of confidentiality and wanting to provide quality care.**

Here are some key issues in performing a risk assessment followed by examples of common statements/questions:

- **Avoid making assumptions** based on gender, age, marital status, disability or other characteristics. For example, just because a male patient is married doesn't mean he is sexually monogamous with his spouse, and it doesn't guarantee he has sex only with women.
- **Be nonjudgmental, direct, and specific** when asking questions regarding sexual behavior, as this may be the best way to "normalize" these behaviors and make the patient more comfortable.
- **Begin with open-ended questions.** They encourage a more complete history and help to open the dialogue.

  Examples of statements to introduce the topic of risk assessment and reinforce confidentiality

"Everything we discuss is strictly confidential and stays between you and me."
"As I do with all my patients, in order to provide you with the best possible care, I am going to ask you several questions related to your current and past sexual activity, and questions about alcohol and drug use."
"I take a sexual and alcohol/drug history with all my patients as part of their health assessment. It's important in order to provide good care."
"I am going to ask you some straightforward questions about your sexual activities and drug use. This is a usual part of the medical history for all patients when they come for a visit. I need to know about this in order to provide the best possible care."
"I know that these subjects are very personal and I divulge the information to no one."

Examples of questions to initiate a sexual risk assessment

> *"Tell me about your sexual partners."*
> *"Tell me about your current partner(s) situation."*

- **Assess the partner situation.** If it doesn't come out clearly with open-ended questions, establish the gender of sexual partners, the number of sexual partners, the nature of the relationships (steady and casual partners), if partners have other partners.

  Examples of questions to elicit information about sexual partners

> *"Do you have sex with men, women, both, or neither?"*
> *"How many sexual partners do you have?"*
> *"Does your partner have other sex partners?"*

- **Assess types of sexual practices** and avoid the use of labels like "gay," "homosexual," or "straight." As previously discussed, identity and behavior may be different. As an example, there is growing evidence that a significant proportion of African-American and Latino MSM identify as heterosexual (5,6), even though they may engage in anal intercourse with other men. Determine the types of sexual contacts: vaginal, oral (insertive and/or receptive), and anal (insertive: "top" and/or receptive: "bottom"). Be aware that patients may engage in oral-anal contact ("rimming"), or digital-anal contact ("fingering" or "fisting") and these behaviors may also carry health risks that need to be evaluated professionally. For example, watch for enteric parasitic infections with rimming, rectal fissures with fisting. If you are uncertain or uncomfortable using the colloquial terms, then it is better to start with the descriptive terms.

  Examples of questions to elicit information about types of sexual practices of MSM with male partners

> *"Do you have oral sex?"*
> *If yes: "Do you put your penis in your partner's mouth?*
> *Do partners put their penises in your mouth?"*
> *"Do you have anal sex?"*
> *If yes: "Do you put your penis in your partner's anus" or*
> *"Have you been a top?"*
> *"Have your partners put their penises in your anus?" or*
> *"Have you been a bottom?"*
> *"Do you put your mouth on your partner's anus?" or*
> *"Do you do rimming?"*
> *"Have partners put their fingers or hands in your anus?" or*
> *"Have you been fingered or fisted?"*

- **Assess sex partner meeting venues**. Ask about travel and sex abroad (important for epidemiologic reasons re: antibiotic resistance, STDs less common in the U.S., etc.), meeting sex partners on the Internet, and at circuit parties, bathhouses, public venues, and bars. Some men may engage in sex with men, or riskier sex, only when traveling. As previously discussed, meeting sex partners at certain venues increases the risk for STD/HIV. Also ask about exchange of sex for money, drugs or shelter.

Examples of questions to ask to elicit information about sex partner meeting venues

> *"Does your sexual behavior change as a result of travel outside your home area, i.e., vacation/business trips?"*
> *"Have you had sex abroad?"*
> *"How do you meet your sex partners?"*
> *"Have you ever exchanged drugs or money for sex?"*
> *"Can you think of a time when you have gone beyond your normal boundaries or done something you know was unsafe; if so, what happened?"*

- **Assess HIV status of patient and sexual partners.** This patient may not be a regular patient of yours, may be a new patient, or may seek STD care or HIV testing elsewhere.

Examples of questions to ask to elicit information about HIV status

> *"On how many occasions have you had sex with a known HIV infected partner?"*
> *"Have you been tested for HIV?"*
> *If so: "When were you last tested for HIV and what was the result?"*
> *If not: "What are the reasons you haven't been tested for HIV?"*
> *"Do you have any concerns regarding HIV testing?"*
> *"Have you been tested for STDs?"*
> *If so: "When were you last tested for STDs and what was the result(s)?"*
> *If not: "What are the reasons you haven't been tested for STDs?"*
> *"Do you have any concerns regarding STD testing?"*

- **Assess experience with condom use**. As appropriate, ask about frequency and circumstances surrounding condom use. Some patients may never use condoms, or may use condoms with casual partners, but may not with their steady partners. Or, they may use condoms for anal sex, but not for oral sex. An open-ended question may provide more (candid) information about the circumstances of condom use.

Examples of questions to ask to elicit information about condom use

> *"What's your experience been with condom use?"*
> *If not used consistently:*
> *"What would be the difference between a time when you would use condoms versus a time when you might not?"*

- **Assess alcohol and drug use**. As stated, drug and alcohol use is prevalent in MSM. The use of club drugs and alcohol can alter coherent thinking patterns regarding sexual safety. Explore the circumstances of use, amount, types of drugs and venues as appropriate.

Examples of questions to ask to elicit information about alcohol and drug use

> *"Tell me about your alcohol use."*
> *"What's you experience been with drug use?"*

- **Summarize the patients' response to your questions**. This will assure the patient that you are listening, and will help clarify any misunderstandings.

- **Finally, assess the patients' history of STDs**, both diagnosis and treatment. Elicit information about date of last STD screening. If the patients' response to any of the questions indicate a high level of risk (e.g., multiple sex partners, unprotected sexual activity, a history of STDs), determine the context in which these behaviors occur, including concurrent use of alcohol, substance use and mood state.

Other examples of questions to understand circumstances surrounding risk

> *"I am trying to better understand the situations in which you engage in sex – do alcohol and/or drugs play a role in your sexual activities?"*
> *If so:*
> *"How much alcohol do you usually consume when you are having sex?"*
> *"What recreational drugs do you use?"*
> *"How often are you high or drunk when you're sexually active?"*
> *"How often are you in situations where there is drinking and/or drugs AND men are meeting sex partners?"*
> *"What substances are usually being used?"*
> *"Does your state of mind influence your behaviors?"*
> *"Have you felt down or depressed when you're sexually active?" If yes:*
> *"Does this impact your level of sexual risk taking, number of partners, or where you meet partners?"*

Counseling strategies

Please consult Section 9 for more information about using stages of change to counsel patients engaging in risky behaviors. Some patients may be "precontemplative" in adopting a "gold standard" behavior (such as consistent condom use). Using harm reduction strategies in these situations can help patients achieve a more realistic goal given their current "stage." Examples of these harm reduction strategies are listed below and may begin with "Let's talk for a minute about some specific skills or strategies to reduce the risk of harm."

- Carry condoms and packets of non-irritating lubricants.
- Discuss condom use with your partner prior to initiating sex.
- Keep condoms readily available where you're most likely to need them.
- Limit drinks, bumps, lines, tokes, etc.
- Alternate alcoholic and nonalcoholic drinks.
- Use less strong drugs, or less concentrated alcohol (e.g., beer versus more potent alcohols).
- If you plan to use drugs, concentrate on using a limited amount of one drug.
- Limit number of sexual partners.
- If you don't use condoms, avoid allowing partners to ejaculate ('cum') in your rectum or mouth.
- Discuss HIV status and history of STDs with sexual partners.

You can discuss the feasibility of these options to risk reduction, and whether or not each is a realistic option for the patient.

Barriers to sexual history taking

Input from medical providers who specialize in MSM healthcare suggests the key obstacles to sexual risk assessments within primary care practices are:

- Lack of provider experience or discomfort with asking questions
- Provider discomfort or inability to respond to issues that arise
- Providers' inability to "normalize" sexual behavior
- Provider uncertainty on how to make the patient comfortable, particularly with regard to discussing same-sex relationships
- Providers making false assumptions regarding sexual behavior and level of risk
- A patients' perception of stigma from a medical care provider
- Cultural norms
- Socioeconomic status
- Mental health and substance abuse

In addition to the barriers listed above, research has documented a high prevalence of homophobia, anti-gay bias, and heterosexism among medical providers. Even physicians who lack biases may not feel comfortable discussing issues relevant to MSM, or may not be aware of the special health needs of MSM (1,7). Because of actual and perceived biases, many MSM may avoid disclosing their sexual orientation to their providers, thus precluding them from providing appropriate care (7,8).

For MSM of color, homophobia, racism and fear of racial discrimination intensifies barriers to receiving quality healthcare and disclosing health information. Physicians often lack sufficient training in medical school and post-graduate training to provide appropriate and culturally competent care for their MSM patients. Medical intake forms and patient educational materials often tend to assume heterosexuality (1,9). All of these factors should be taken into account when conducting a risk assessment, as they have potential to act as barriers.

Some steps for addressing these include:

- Developing a practice policy for when and where a sexual risk assessment will be initiated
- Determining how this will be integrated into the patients' overall care
- Identifying the specific questions that will be asked
- Developing a plan to respond to the information that might surface
- Training staff in how to perform a risk assessment

Charting risk assessment history

Charting systems can be a major barrier to documenting risk assessments. Office practices vary in how to handle charting of risk assessments and each system has its benefits and limitations. Some keep all patient information in one centralized record, which is convenient for providers but potentially problematic for issues of confidentiality. Others create a shadow record or separately designated section of each record for recording confidential information that is only available for review by the medical provider and/or patient. This method seems best for the issue of confidentiality; however, it requires the provider to review two charts and could lead to overlooking important information. Yet others use abbreviations or codes for laboratory results and diagnostic information. This system can create problems in that the coding system may be too complex or may not be used by everyone in the practice, so it may be difficult for others to decipher. Lastly, it is important to remember that your patients have legal access to their medical records, and they should be able to clearly understand what has been documented.

Your practice will need to consider how much detail to include in the patient record and how to best protect the confidentiality of this information. Some questions to ask to help determine what is best for your office include:

1) Do your patient history forms include questions regarding sexual risk assessment? If not, how will you document that a comprehensive sexual risk assessment has been obtained, and how will you document updated versions?
2) Do your patient history forms provide for optional self-identification in all categories of gender identity, sexual orientation, marital, partnership and family status and provide clients with the option and opportunity for further written explanation?

In order to make the clinical encounter more efficient, your setting might consider using a risk questionnaire to be administered in the waiting area or mailed to the patient's home, prior to the initiation of the visit.

For more information see *MDPH Basic Behavioral Risk and Health Assessment Guide for Assessing Health and Behavioral Risk for HIV, STDs and Viral Hepatitis* and *Patient-Administered Sexual Health Risk Questionnaire* in Section 12.

Key Counseling Issues

- **Make no assumptions about the behaviors of patients**
- **Make risk assessment routine for all patients**

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Section 7
STD Screening Recommendations
Summary Points

Key Clinical Issues

Why screen men who have sex with men (MSM) for sexually transmitted diseases (STDs)?

- **STDs are on the rise in MSM**
- **STDs increase the risk of human immunodeficiency virus (HIV) transmission and acquisition**
- **STDs are often asymptomatic**

When should MSM be screened for STDs?

- **STD screening (HIV, syphilis, gonorrhea) should be performed on all sexually active MSM regardless of the patient's history of consistent condom use**

Section 7: STD Screening Recommendations

Rationale for screening men who have sex with men (MSM)

There are several reasons to screen MSM routinely for sexually transmitted diseases (STDs). As discussed in Section 1, MSM are at increased risk for certain STDs, and the incidence of syphilis and gonorrhea has risen in MSM in Massachusetts and in other parts of the U.S. In addition, many STDs are typically asymptomatic, such as pharyngeal and anal gonococcal infections, or have symptoms that are easily missed, such as the chancre of syphilis.

Primary care clinicians are in a unique position to provide screening and counseling services to MSM. Centers for Disease Control and Prevention (CDC) data suggest that most (65% to 85%) MSM receive primary health care from a private provider, with fewer (2% to 5%) receiving their care from public health and community clinics (1). By screening patients as part of routine primary care, providers have the ability to make a significant impact on STD prevention efforts both locally and nationally.

Key Clinical Issues

Why screen MSM for STDs?

- **STDs are on the rise in MSM**
- **STDs increase the risk of HIV transmission and acquisition**
- **STDs are often asymptomatic**

Recommended steps for STD screening

1. Identify sexually active MSM through routine sexual history taking (1).

Conducting a culturally sensitive sexual history to identify risk of STD exposure is typically the fist step in STD screening. During a patient interview, substance use history (including Viagra) should also be routinely assessed, as drug use has been associated with higher risk sexual behavior and STDs, as well as underlying social and psychological problems. See Section 6 for suggestions on conducting a risk assessment with MSM patients. See Section 2 for information on patterns of sexual and drug risk behavior in MSM.

2. Ask about symptoms consistent with the presence of a STD (2).

Ask patients if they are experiencing any symptoms consistent with STDs, bearing in mind that many STDs may be asymptomatic. Common symptoms include dysuria, urethral discharge, skin rash, and anorectal pruritis, pain, and discharge.

For more information see *Important Findings at Examination & Specimen Collection in Men* in Section 12.

3. Consistently provide the following recommended STD clinical prevention services (1,2,3,4).

Screen (at least annually):

- For STD signs (visual inspection of the skin, mouth, genital and anal area)
- For human immunodeficiency virus (HIV) infection
- For syphilis
- For *Neisseria gonorrhoeae* at exposed sites

These screenings should be performed in all sexually active MSM, regardless of the patient's history of consistent condom use.

For MSM at highest risk (multiple partners, partners met through the Internet, unprotected anal intercourse, having sex in conjunction with substance use), STD screening should be performed more frequently (every three to six months).

Vaccinate:

- For hepatitis A and B, all susceptible MSM (no history of hepatitis infection or vaccine)

For more information on hepatitis A and B vaccination see *Dear Colleague Letter, Pocket Card, Poster & Fact Sheet* in Section 12 or visit:
www.cdc.gov/ncidod/diseases/hepatitis/msm/

4. Consider screening for other STDs.

Chlamydia trachomatis

All MSM presenting with urethritis should be tested for chlamydia. However, routine chlamydia screening of asymptomatic males has not been uniformly recommended by professional organizations. Because prevalence of *Chlamydia trachomatis* varies in asymptomatic MSM, chlamydia screening should be considered on a case-by-case basis.

Lymphogranuloma venereum (LGV)

No cases of rectal LGV had been reported in Massachusetts as of January 2005; however, CDC advises clinicians who care for MSM to consider LGV in the diagnosis of compatible syndromes (e.g. proctitis and proctocolitis) and perform tests to diagnose *Chlamydia trachomatis* infections without regard to the specific LGV strains. Contact the Division of STD Prevention (DSTDP) at 617 983-6940 if you suspect a case of LGV. They can assist in direct identification and serologic testing for *Chlamydia trachomatis* in cases compatible with LGV as well as with partner management services.

For more information see *MDPH LGV Clinical Advisory* at:
www.mass.gov/dph/cdc/std/divstd.htm

For the full MMWR report on *Lymphogranuloma Venereum Among Men Who Have Sex with Men --- Netherlands, 2003—2004* see Section 12 or visit:
www.cdc.gov/mmwr/preview/mmwrhtml/mm5342a2.htm

Herpes simplex virus (HSV)
Herpes simplex virus (HSV) infections are common in MSM (5, 6). Persons infected with HSV may have few or no symptoms, but still shed virus. Both symptomatic and asymptomatic HSV infections increase the risk of transmitting or acquiring HIV infection (7).

Serological testing to identify HSV-infected MSM, using type specific tests for antibody to HSV glycoprotein G, should be considered. If antibody testing is positive, especially for HSV-2, patients should be informed of the increased risk of acquiring or transmitting HIV infection. They should be educated about symptoms of HSV, including mild and prodromic, so they can learn to recognize them. Abstaining from sexual contact during prodromal/symptomatic episodes and using condoms for all sexual contacts are the target behavior goals. Symptomatic patients may benefit from suppressive therapy.

For more information on type-specific serology see *Summary Guidelines for the Use of Herpes Simplex Virus (HSV) Type 2 Serologies* in Section 12 or visit: www.stdhivtraining.org/pdf/HSV_guidelines_summary.pdf

Human papilloma virus (HPV)
There is currently no commercially available FDA-approved HPV test for men and no rationale to screen for HPV infection. Visual inspection is sufficient to detect warts caused by HPV. The natural history of anal HPV and treatment efficacy have not been well described, so the CDC does not currently recommend screening men for anal squamous intraepithelial lesions (SIL).

Key Clinical Issue

- **STD screening (HIV, syphilis, gonorrhea) should be performed in all sexually active MSM regardless of the patient's history of consistent condom use**

Testing approaches

HIV

- **Enzyme Immunoassay (EIA) and Western Blot (WB)**
  The EIA test, followed by confirmation with the WB, remains the standard for detecting antibodies to HIV and requires drawing venous blood or collecting oral mucosal tissue. Test results are generally available within one to two weeks.

- **Rapid Testing**
  Since 2002, FDA approved HIV rapid tests have been available. The OraQuick® can be used on whole blood collected either through finger stick or venipuncture. It has the best test performance characteristics and is CLIA waived. Tests can be read after 20 minutes (no sooner than 20 minutes but no later than 40 minutes).

Reported sensitivity and specificity exceed 99%. However, it is important to note that all reactive results from rapid tests require confirmation. Patients should be counseled accordingly. Specifically, the "CDC emphasizes that reactive rapid HIV tests must be confirmed with WB or immunofluorescent assay (IFA), even if a subsequent EIA is nonreactive. If such confirmatory testing yields negative or indeterminate results, follow-up testing should be performed on a blood specimen collected 4 weeks after the initial reactive rapid HIV test result."(9)

More recently (2004), the OraQuick® (also referred to as OraSure®) was FDA approved for testing oral fluid, and has been CLIA waived.

HIV Rapid Testing Websites

- For more information on the OraQuick® using blood samples, visit: www.cdc.gov/hiv/PUBS/faq/oraqckfaq.htm
- For more information on the OraQuick® using oral fluid, visit: www.cdc.gov/hiv/rapid_testing/materials/oralfluidqandafin1_1.pdf
- For general information on rapid HIV tests and counseling, visit: www.cdc.gov/hiv/rapid_testing

Massachusetts specific HIV testing information can be found in the *HIV/AIDS, Hepatitis, STD and Substance Use Services and Resources* in Section 12 or visit: www.mass.gov/dph/aids/services/hivresourceguide.pdf

Syphilis

For screening of syphilis, request the blood test, rapid plasma reagin (RPR). Positive RPRs should be confirmed with *Treponema pallidum* particle agglutination test (TP-PA) or fluorescent treponema antibody absorption test (FTA-ABS).

Neisseria gonorrhoeae

Test all exposed anatomical sites for gonorrhea.

- **Urethra:** Use a urethral culture or urethral/urine nucleic acid amplification test (NAAT). Cultures, particularly for symptomatic urethritis, have the added advantage of antibiotic sensitivity testing. This is important given the rise of quinolone resistant Neisseria gonorrhoeae in Massachusetts and other areas of the U.S.
- **Pharynx:** Use culture. Culture is currently the only FDA approved test for the pharynx.
- **Anus:** Use culture. Culture is currently the only FDA approved test for the rectum.

Chlamydia trachomatis

The prevalence of chlamydial infections in MSM varies geographically. Consider testing the urethra and anus, if exposed.

- **Urethra:** Use urethral/urine NAAT. NAATs are the most sensitive tests for the detection of *Chlamydia trachomatis*.

- **Pharynx:** Testing not currently routinely recommended. Culture is the only FDA approved test for the pharynx.
- **Anus:** Use culture. Culture is the only FDA approved test for the rectum.

For more information on screening tests to detect *Neisseria gonorrhoeae* and *Chlamydia trachomatis* see the *Screening tests to detect Neisseria gonorrhoeae and Chlamydia trachomatis infections – 2002 MMWR*:
www.cdc.gov/mmwr/preview/mmwrhtml/rr5115a1.htm

Nucleic acid amplification tests (NAATs)

- NAATs available for detecting gonorrhea and chlamydia include:
  - Strand Displacement Assay (SDA): ProbeTec®
  - Transcriptase Mediated Amplification (TMA): Aptima®
  - Polymerase Chain Reaction (PCR): Amplicor®
- NAATs are FDA approved for urethral/cervical and urine samples – but NOT for anal and pharyngeal samples*
- NAATs are the most sensitive tests to detect chlamydia

*Some clinicians choose to use NAATs for these non FDA-approved sites. Although most NAATs appear to be specific (no cross reaction with other pharyngeal or rectal bacteria), the interpretation of the result of these tests is difficult given the limited data on their performance at these anatomical sites. CDC does not recommend their use at this time.

Testing Approach Summary		
STD	**Site**	**FDA Approved Tests**
HIV	Blood	EIA; confirm reactives with WB
	Blood	OraQuick (rapid); confirm reactives with WB or IFA
	Oral Fluid	OraQuick/OraSure (rapid); confirm reactives with WB or IFA
Syphilis	Blood	RPR; confirm reactives with TP-PA or FTA-ABS
Gonorrhea	Urethra	Culture or NAAT (urine or urethral swab)
	Pharynx	Culture
	Anus	Culture
Chlamydia	Urethra	NAAT (urine or urethral swab)
	Pharynx	Culture (but testing not routinely recommended)
	Anus	Culture

Hepatitis vaccinations

Hepatitis A

Susceptible MSM (those who have no history of hepatitis infection or vaccine) should receive hepatitis A vaccine. Serological testing prior to vaccination is not routinely recommended in Massachusetts because studies conducted in 1998 have demonstrated a low prevalence of immunity in MSM. Indeed, it was found that out of 762

participants, a minority had evidence of previous hepatitis A infection or vaccination (14%) (10). Prevaccination testing may be cost-effective in other states and settings, but should not be a barrier to vaccination for susceptible persons. If prevaccination testing is done, the first vaccine dose should be administered at the same time as serologic testing. There is no harm in vaccinating people who are already immune. Post-vaccination testing is not recommended.

HEPATITS A VACCINATION

Vaccine	Dose	Volume (mL)	Schedule (Months)
HAVRIX®[1]	1,440 EL.U.	1.0	0, 6-12
VATA®[2]	50 U	1.0	0, 6-12
Twinrix®[3]	**	1.0	0, 1-2, 6-12

[1]inactivated hepatitis A vaccine, GlaxoSmithKline; EL.U. = Enzyme-linked immunosorbent assay units; 2-dose schedule
[2]inactivated hepatitis A vaccine, Merck & Co., Inc., U – Units; 2-dose schedule
[3]combined hepatitis A-hepatitis B vaccine, GlaxoSmithKline, 3-dose schedule
**720 EL.U. hepatitis A vaccine, 20mcg hepatitis B vaccine

Hepatitis B

For MSM who do not report a history of vaccination, serological testing (antibody to hepatitis B core antibody (HbcAb) is the test of choice) prior to hepatitis B vaccination may be cost-effective because the prevalence of naturally acquired immunity is high (more than 30%). Due to immunization requirements in Massachusetts, most young men who have spent at least half of their lives in this state are likely to have been immunized for hepatitis B. In the 1998 study quoted above, MSM were also tested for hepatitis B virus (HBV). It was found that 1% had laboratory evidence of current infection, 22% had evidence of past infection and 28% of the participants had evidence of past vaccination against HBV. Overall, 51% of MSM were not hepatitis B vaccine candidates.

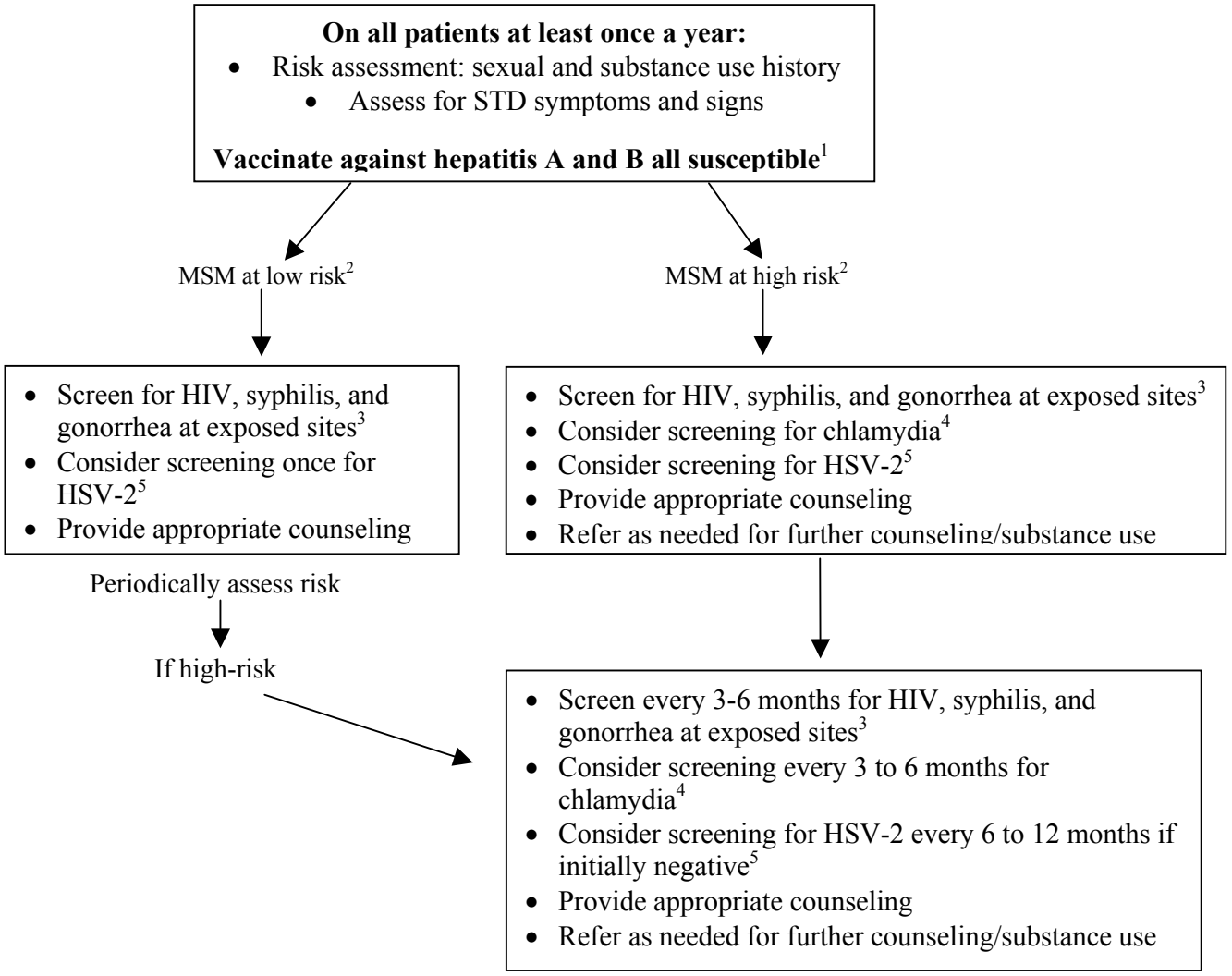
If follow-up to serologic testing is uncertain, vaccine should be administered at the time of the serological test, as immunization is not harmful in previously infected (whether immune or chronic carrier) or vaccinated persons. The immunization course (additional two doses) should be completed for susceptible persons. Post-vaccination testing is recommended for immunocompromised persons and for sex partners of persons with chronic hepatitis B infection. Testing should be conducted one to three months after the third vaccination dose.

HEPATITS B VACCINATION

Vaccine	Dose	Volume (mL)	Schedule (Months)
ENGERIX-B®[1]	20 mcg	1.0	0, 1-2, 4-6
Recombivax®[2]	10 mcg	1.0	0, 1-2, 4-6
Twinrix®[3]	**	1.0	0, 1-2, 6-12

[1]recombinant hepatitis B vaccine, GlaxoSmithKline; 3-dose schedule
[2]recombinant hepatitis B vaccine, Merck & Co., Inc.; 3-dose schedule
[3]combined hepatitis A-hepatitis B vaccine, GlaxoSmithKline; 3-dose schedule
**720 EL.U. hepatitis A vaccine, 20mcg hepatitis B vaccine

STD Screening Recommendations for MSM



[1]no history of hepatitis infection or vaccine
[2]indicators of low risk include being in a mutually monogamous relationship with an uninfected partner, or consistent condom use or no rectal intercourse. Indicators of high-risk include having sex with multiple or anonymous partners/partners met through the Internet, sex in conjunction with drug use, and unprotected anal intercourse. It's important to note that anyone may transition from low to high risk, and vice-versa, hence the importance of regular assessment.
[3]urethra: urethral culture or urethral/urine NAAT; pharynx: culture if oral-genital sex; anus: culture if receptive anal sex
[4]urethra: urethral culture or urethral/urine NAAT; anus: culture if receptive anal sex
[5]use type-specific serology

Screening recommendations for HIV-infected MSM

Routine screening for gonorrhea, chlamydia, syphilis, and genital herpes is recommended for HIV-infected men and should be provided as part of ongoing HIV primary care. Screening HIV-infected MSM can play an important role in reducing HIV transmission, since most STDs promote increased shedding of HIV, and because HIV seropositivity is a risk correlate of STDs**.** For example in 2003, more than 40% of men with infectious syphilis in Massachusetts were known to be HIV co-infected.

Screening recommendations for HIV-infected MSM include periodic sexual and substance use histories and at least annual testing. HIV-infected MSM should also be vaccinated for hepatitis A and B (if they have no serological evidence of immunity or chronic hepatitis).

For more information about the care of HIV-infected men please see the *Prevention and Management of STDs in Persons Living with HIV/AIDS* (15): depts.washington.edu/nnptc/online_training/PrevMgmt-STDHIV_Sept03.pdf and *Incorporating HIV Prevention in the Medical Care of Persons Living with HIV* (16): www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm

Billing concerns

STD testing is covered by most U.S. health insurance plans. Surveys of major health insurers indicate that preventive care services (including vaccination and testing) are increasingly covered for persons at risk, under plans with a preventive care component. For instance, Harvard Pilgrim Health Care's 2003 Adult Preventive Care Recommendations include STD screening for persons at risk, and vaccination for hepatitis A and B for persons at high risk and not previously immunized.

Health insurers report that specific risk factor data is not required for reimbursement. An assessment by a clinician that the preventive care service is "medically indicated" is usually sufficient.

Office billing staff may need training in appropriate codes that allow for reimbursement. For more information on seeking reimbursement for hepatitis vaccine see *Coding Guidelines for Vaccine-Preventable Hepatitis (VPH)* in Section 12 or visit: www.cdc.gov/ncidod/diseases/hepatitis/msm/04-0103_trifold.pdf

Special issues

Non-occupational HIV post-exposure prophylaxis (nPEP)

Patients who have had a recent sexual contact with a partner who is HIV-infected or of unknown HIV serostatus may be candidates for nonoccupational post-exposure prophylaxis (nPEP). nPEP is the use of antiretroviral therapy to prevent the development of HIV infection in someone potentially exposed to the virus through a sexual contact, injection drug use, or other nonoccupational pathway. The few human observational and animal studies on nPEP efficacy demonstrate that nPEP may reduce the risk for acquiring HIV infection (11,12,13). In addition, studies of post-exposure prophylaxis for health care workers and maternal-infant exposure suggest efficacy (14,15).

In January 2005, the Department of Health and Human Services (DHHS) issued the revised recommendations for the use of nPEP in the U.S. A summary of the recommendations follows (11):

- For persons seeking care $\leq$ 72 hours after nonoccupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person known to be HIV-infected, when that exposure represents a substantial risk for transmission, a 28-day course of highly active antiretroviral therapy (HAART) is recommended. Antiretroviral medications should be initiated as soon as possible after exposure.
- For persons seeking care $\leq$ 72 hours after nonoccupational exposure to blood, genital secretions, or other potentially infectious body fluids of a person of unknown HIV status, when such exposure would represent a substantial risk for transmission if the source were HIV-infected, no recommendations are made for the use of nPEP. Clinicians should evaluate risks and benefits of nPEP on a case-by-case basis.
- For persons with exposure histories that represent no substantial risk for HIV transmission or who seek care >72 hours after exposure, DHHS does not recommend the use of nPEP. Clinicians might consider prescribing nPEP for exposures conferring a serious risk for transmission, even if the person seeks care >72 hours after exposure if, in their judgment, the diminished potential benefit of nPEP outweighs the risks for transmission and adverse events.
- For all exposures, other health risks resulting from the exposure should be considered and prophylaxis administered when indicated. Risk-reduction counseling and indicated intervention services should be provided to reduce the risk for recurrent exposures.
- No evidence indicates that any specific antiretroviral medication or combination of medications is optimal for use as nPEP. However, on the basis of the degree of experience with individual agents in the treatment of HIV-infected persons, certain agents and combinations are preferred. Preferred regimens include efavirenz and lamivudine or emtricitabine, with zidovudine or tenofovir (as a nonnucleoside-based regimen) and lopinavir/ritonavir (coformulated in one tablet as Kaletra®) and zidovudine, with either lamivudine or emtricitabine. Different alternative regimens are possible.

In addition, the following should be considered for patients treated with nPEP:

- Scientific consultation with infectious disease or other HIV-care specialists (if available immediately) when clinicians are not experienced with using HAART
- Facilitating adherence to medications through education about side effects, consultation, encouragement, and prescribing fewer doses per visit
- Follow-up HIV testing and care at four to six weeks, three months, and six months after exposure
- HIV prevention counseling and other behavioral intervention, education, and services
- Management of source persons, if known
- Attention to high level of confidentiality if reporting STDs or HIV infection

The MMWR regarding nPEP, please see *Antiretroviral Postexposure Prophylaxis After Sexual, Injection-Drug Use, or Other Nonoccupational Exposure to HIV in the United States*:
www.cdc.gov/mmwr/preview/mmwrhtml/rr5402a1.htm

nPEP resources

In Massachusetts, several centers have developed expertise in responding to acute requests for occupational and non-occupational post-exposure prophylaxis. Fenway Community Health (FCH) has provided nPEP to more than 500 individuals, in programs and studies supported by the CDC, Massachusetts Department of Public Health (MDPH), and industry sponsors. The long-term experience at FCH suggests that nPEP users often have co-existent substance use and mental health issues, so triage to behavioral counseling specialists should be integrated into nPEP programs to maximize the educable moment for risk reduction. MDPH has also supported programs in the Emergency Departments of University of Massachusetts Medical Center and Lawrence General Hospital to provide nPEP and counseling for the survivors of sexual assault.

For more information on nPEP protocols visit: www.mass.gov/dph/aids/services/pep.htm

- Providers who are unsure if PEP should be administered should call the National Clinicians' Post-Exposure Prophylaxis Hotline (PEPline) at 1-888-448-4911 to determine if PEP should be administered, and for advice on a recommended treatment regimen

- For referrals to Fenway Community Health, call (617) 927-6045 Monday through Friday, 8:00 a.m. to 8:00 p.m. or (617) 267-0900

Additional articles on nPEP include:

- Lurie P, et al. Postexposure prophylaxis after nonoccupational HIV exposure. *JAMA* 1998; 280:1769-1773.
- Katz MH and Gerberding JL. Postexposure treatment of people exposed to the human immunodeficiency virus through sexual contact or injection drug use. *N Engl J Med* 1997;336:1097-100.

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Sexual assault and domestic violence

More than one in six gay men report having been sexually assaulted according to the National Gay Men's Survey 1998. For MSM, sexual assault can lead to feelings of humiliation, self-blame, and self-loathing attached to their sexuality. The recovery process from sexual assault is often extremely painful. Clinicians should also be aware of the potential for domestic violence in MSM patients.

Providers can be prepared for these situations by knowing the resources available for MSM patients. Resources include:

- The Sexual Assault Nurse Examiner Program (SANE). SANE provides protocols for the evaluation of sexual assault survivors, counseling resources, and recommended STD/HIV prophylaxis. For more information, call the SANE program at (617) 624-5432) or visit: www.mass.gov/dph/fch/sane/index.htm
- The Sexual Assault Prevention and Survivor Services, visit: www.mass.gov/dph/fch/sapss/index.htm
- Fenway Community Health Violence Recovery Program at (617) 927-6250 or toll-free (800) 834-3242 or visit: www.fenwayhealth.org/services/violence.htm
- The National Domestic Violence Hotline Website, visit: www.ndvh.org/index.html

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Section 8
Sexually Transmitted Diseases Treatment Guidelines

Massachusetts Treatment Guidelines

This section contains the MDPH – Division of STD Prevention 2004 STD Treatment Guidelines. The guidelines can also be found at:
www.mass.gov/dph/cdc/std/guidelines/trtmntguide.pdf

National Treatment Guidelines

The 2002 Centers for Disease Control and Prevention (CDC) Treatment Guidelines and downloadable PDA Treatment Guidelines can be found at:
www.cdc.gov/std/treatment/default.htm
www.cdcnpin.org/scripts/std/pda.asp

Section 9
Behavioral Counseling
Summary Points

Key Elements of Effective Behavioral Counseling

- **Use open-ended questions to assess the patient's history of, and attitudes towards, sexually transmitted disease (STD) and human immunodeficiency virus (HIV) risk behaviors**
- **Ask about the patient's circumstances that relate to his risk behaviors**
- **Maintain the communication as interactive, non-judgmental, and focused on the patient's circumstances**
- **Work with the patient as an active participant to develop a realistic risk reduction plan**

Additional Core Elements of Stage-Based Behavioral Counseling

- **Conduct a behavioral risk assessment**
- **Complete a staging assessment. Identify a target behavior and assess the patient's readiness to adopt or adhere to that behavior.**
- **Select and use a counseling strategy that matches the patient's stage of readiness for change. In this way, you are using a client-centered approach, which is most likely to be effective in influencing behavior change.**
- **Document the stage, counseling strategy used, and patient's plan/first steps for continuity of care and evaluation of effectiveness.**

Section 9: Behavioral Counseling

It is clear that, although patient education about human immunodeficiency virus, acquired immune deficiency syndrome (HIV/AIDS), sexually transmitted diseases (STDs) and their consequences increases knowledge, it is not effective on its own for sustained behavior change (1,2). Other interventions are necessary for primary prevention. As mentioned in previous sections, the use of staged-based behavioral counseling (SBC) may assist in reducing risk behaviors. This section reviews a four-step process of using these interventions. In addition, Section 12 has several stage-based counseling examples, stage of change and Transtheoretical Model processes of change matched to SBC strategies, and information giving counseling strategies.

Theory-based interventions, derived from social and behavioral science, have demonstrated positive results in effecting behavior change, including sexual and substance use behaviors (3). The National Institutes of Health (NIH) conducted a review of HIV prevention interventions and stated that short-term, provider delivered, brief counseling interventions provided in clinical settings demonstrated evidence of effectiveness (4).

Centers for Disease Control and Prevention (CDC) Guidelines for STD/HIV Prevention Counseling recommend that methods used for counseling be science-based, interactive, non-judgmental, focused on the client's individual circumstances, and directed towards working with the client as an active participant to develop a realistic risk reduction behavior plan (5).

There are many challenges to implementing behavioral counseling in a busy, real-world, clinical setting. Time constraints are significant, so interventions must be brief if delivered by clinicians during the medical visit.

The theoretical framework of stage-based behavioral counseling is used by health care providers to deliver brief counseling interventions in clinical settings for cardiovascular risk reduction, promotion of physical activity, and diet change (6,7). This theory of behavior change has been adapted to behavioral counseling for STD/HIV prevention for all patients (8,9,10). Stage-based behavioral counseling allows a clinician to assess each client's stage of readiness for change and then use appropriate behavioral counseling in the same way they currently "diagnose" and "treat" medical problems. The clinician can efficiently determine an accurate starting point for each client, use an appropriate counseling strategy, and set realistic goals for the outcome of the session.

The following pages will describe the key elements of behavioral counseling and how to conduct stage-based behavioral counseling.

Key Elements of Effective Behavioral Counseling

- **Using open-ended questions to assess the patient's history of, and attitudes towards, STD/HIV risk behaviors**
- **Asking about the patient's circumstances that relate to his risk behaviors**
- **Maintaining the communication as interactive, non-judgmental and focused on the patient's circumstances**
- **Working with the patient as an active participant to develop a realistic risk reduction plan**

Stage-Based Behavioral Counseling for STD/HIV Risk Reduction

Stages of change/transtheoretical model of behavior change was adapted for STD/HIV risk reduction by the Center for Health and Behavioral Training (CHBT) at the University of Rochester as an individual-level intervention named the Stage-Based Behavioral Counseling (SBC). The CHBT is part of the National Network of STD/HIV Prevention Training Centers, and is a collaboration of the University of Rochester and the Monroe County Department of Health in Rochester, NY (7,8).

Step 1

Conduct a behavioral risk assessment. (See Section 6 for how to conduct a risk assessment.)

Step 2

Complete a staging assessment. Identify a target behavior and assess the patient's readiness to adopt or adhere to that behavior.

Target behaviors

There are many behaviors that will reduce the risk of STD/HIV transmission. These are called target behaviors. Target behaviors include any sexual, substance use, and health care seeking behavior that will reduce the chances that a patient will acquire or transmit STD/HIV. Gold standard target behaviors are those which would result in the greatest reduction of risk, while harm reduction target behaviors are seen as a 'first step' in a continuum of behavior change. Examples of target and harm reduction behaviors for patients are listed below.

Gold standard target behaviors for sexual risk reduction for all patients:

- Delay or avoid sexual intercourse
- Be in a mutually monogamous relationship with an uninfected partner
- Use a male condom consistently for sexual intercourse

Harm reduction target behaviors for patients who are not ready for the above:

- Get STD/HIV testing regularly
- Use condoms consistently with outside partners
- Reduce the number of sexual partners

- Increase the number of times condoms are used for penetrative sex
- Use non-penetrative sexual practices
- Put the condom on right before ejaculation
- Any "first step" a patient is willing to make

Gold standard target behaviors for substance use risk reduction:

- Stop using
- Enter a substance use treatment program
- Use needle exchange if injecting drugs to avoid needle sharing

Harm reduction target behaviors for patients who are not ready for the above:

- Avoid sexual venues where drug use/high alcohol intake is prevalent
- Avoid drugs likely to lead to high-risk behaviors
- Reduce the number of times/quantity you are using drugs
- Don't have sex when you are high
- For injecting drug users, use in a less harmful way e.g., snort rather than shoot
- Any "first step" that a patient is willing to take

Staging

Identify the target behavior(s) and assess the patient's 'readiness' to adopt or adhere to that behavior.

A staging assessment is used to identify which of the target behaviors would realistically result in risk reduction for an individual patient and is then used to assess the patient's stage of readiness for adopting or adhering to that target behavior. To correctly identify the appropriate target behavior and classify the patient's stage of change (SOC), the clinician interviews the patient using a series of open-ended staging questions. Some of the staging questions are already a part of the sexual/substance use history. However, in addition to the history of risk behaviors, staging requires an exploration of the patient's attitudes (about condom use, STD/HIV testing, substance use).

Stages of change

- Precontemplative: sees no need to adopt target behavior
- Contemplative: sees the need to adopt target behavior, but has barriers
- Ready for Action: ready to start adopting target behavior or has been engaging in the behavior for zero-three months
- Action: has been engaging in the target behavior for three-six months
- Maintenance: has been engaging in the target behavior for more than six months

<u>Step 3</u>

Select and use a counseling strategy that matches the patient's stage of readiness for change. In this way, you are using a client-centered approach, which is most likely to be effective in influencing behavior change.

SBC Counseling Strategies Matched to SOC

STAGE of CHANGE	COUNSELING STRATEGY
Precontemplative Client sees no need to do the target behavior NO WAY	*Story-telling*: Tell client a story about a case similar to his *Information giving*: Give information specific to client's situation *Discuss impact of behavior on others*: Help client to see how the behavior is negatively impacting persons the client cares about
Contemplative Client sees the need to do the target behavior, but has barriers YES, BUT……..	*Explore ambivalence/offer substitutes*: Help client understand his barriers to change. Discuss pros and cons by exploring the client's cost/benefit to change, and offer harm reduction options *Discuss behavior in relation to self image*: Discuss the client's self-image and how it conflicts with the behavior
Ready for Action Client is ready to do the target behavior and may already be trying LET'S DO IT	*Develop a plan*: Help the client to articulate a specific plan detailing how the client will accomplish the behavior change. Build confidence, practice skills and establish a first step. Increase access to prevention devices and services by referral
Action & Maintenance Client has been doing the target behavior for 3 - 6 months OR more than 6 months DOING IT, then LIVING IT	*Identify supports*: Help client find a support system *Avoid cues*: Assist client in recognizing and avoiding cues which led to risky behaviors *Find substitutes*: Find substitutes for previous risky behavior *Identify rewards*: Help client identify meaningful reward for maintaining the change *Become a role model*: Help client become a role model of change for peers

Step 4
Document the stage, counseling strategy used, and patient's plan/first steps for continuity of care and evaluation of effectiveness.

This can be done efficiently without additional forms by modifying the current visit record to include the following:

- Stages of change target behavior
- Counseling strategy used
- Immediate outcome and patient's plan and next steps

Core Elements of Stage-Based Behavioral Counseling

- **Conduct a behavioral risk assessment**
- **Complete a staging assessment. Identify a target behavior and assess the patient's readiness to adopt or adhere to that behavior.**
- **Select and use a counseling strategy that matches the patient's stage of readiness for change. In this way, you are using a client-centered approach, which is most likely to be effective in influencing behavior change.**
- **Document the stage, counseling strategy used, and patient's plan/first steps for continuity of care and evaluation of effectiveness.**

For more information/training on how to conduct SBC, see *Examples of Counseling Strategies Using the SBC*:
www.urmc.rochester.edu/chbt

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Section 10
Reporting and Partner Services
Summary Points

Key Partner Services Issues

- **The Division of Sexually Transmitted Disease Prevention (DSTDP) routinely conducts partner services (PS) only for reported cases of infectious syphilis, rectal gonorrhea, quinolone-resistant *Neisseria gonorrhoeae* (QRNG), chancroid and lymphogranuloma venereum (LGV)**
- **The DSTDP is available to discuss PS with clinicians in other circumstances**
- **The DSTDP always contacts the clinicians before communicating with the patient**

Key Consent Issue

- **In Massachusetts, partners can be contacted either by the health care provider or the DSTDP only if the patient consents**

Key HIV Partner Counseling and Referral Service Issues

- **Human immunodeficiency virus (HIV) partner counseling and referral service (PCRS) prevents new infections and refers those infected into care**
- **Massachusetts General Laws prohibits disclosing the results of an HIV antibody or antigen test without first obtaining the subject's written informed consent**
- **Given the option, patients may chose to speak with the Disease Intervention Specialist (DIS) and this contact may be facilitated and arranged through the health care provider**

Section 10: Reporting and Partner Services

Reporting of STDs

Clinicians are required to report cases of sexually transmitted diseases (STDs) promptly and directly to the Massachusetts Department of Public Health (MDPH), Division of STD Prevention (DSTDP) and complete the demographic and clinical information requested on the reporting cards. DSTDP staff will contact the reporting clinician if information is missing from these cards. The cards list the reportable STDs, provide information on treatment recommendations and review partner services information.

Although laboratories are also required to report positive test results, demographic and clinical information generally are not included on these reports. Laboratory reports are merged with clinician reports. STD reporting cards can be obtained from the MDPH by calling 617-983-6940 Monday through Friday, 8:00 a.m. to 5:00 p.m.

Partner services of persons with an STD

In order to prevent STD re-infection and/or further transmission of disease, it is critical that evaluation and treatment of the sexual partner(s) be addressed when seeing patients with STDs. This has been identified as partner services (PS), which includes STD partner notification (PN) and human immunodeficiency virus (HIV) partner counseling and referral services (PCRS). HIV PCRS is covered later in this section. There are a number of ways of providing partner services. The first is "self-referral" in which the person with the STD directly informs partner(s), either verbally or in writing. The second is "provider referral," in which the person with the STD voluntarily divulges partner information to a disease intervention specialist (DIS) from the DSTDP, who then locates and informs the partner of possible exposure. A third mechanism is sometimes called "conditional referral" in which the person with the STD and the DIS agree to allow a certain amount of time for self-referral. If it is not done, then the DIS will do the notification. Finally, another mechanism, by which a partner may be informed, is by a physician or other clinician with the consent and cooperation of the patient (a form of provider referral). Because this may be time consuming for clinicians, it may not occur very frequently. Nevertheless, partner services should be considered a priority especially if requested by the patient.

Partner notification is voluntary and patient confidentiality is protected by law. **In Massachusetts, partners cannot be contacted, either by the health care provider or the DSTDP, unless the patient agrees.** Therefore, the best approach is to discuss with the patient the benefits of and other considerations related to partner evaluation and treatment, thus facilitating patient's informed decision-making. In addition, conducting PN assumes that the patient has identifying and locating information for the partners, which is often not the case for patients with multiple anonymous partners.

Laws regarding partner notification for STDs and HIV infection differ from state to state; please consult the STD Division in your state for more information.

The role of the DSTDP

The DSTDP does not conduct partner services for all reported STDs. Unfortunately, it would not be possible to offer the service to the more than 13,000 cases of STDs reported in Massachusetts each year.

The DSTDP conducts PS routinely for designated public health "priority cases" which include all reported cases of infectious syphilis, rectal gonorrhea, quinolone-resistant Neisseria gonorrhoeae (QRNG) and unusual STDs such as chancroid and lymphogranuloma venereum (LGV). This means that the DSTDP will attempt to contact all "priority cases" for an interview. The DSTDP always contacts the health care provider before communicating with the patient to confirm the diagnosis and inform of the intent of offering PS. Patients will be directly contacted by the DSTDP only if all attempts to reach the health care provider fail. DIS have been trained to provide services sensitive to men who have sex with men (MSM).

Key Partner Services Issues

- **The DSTDP routinely conducts PS only for reported cases of infectious syphilis, rectal gonorrhea, QRNG, chancroid and LGV**
- **The DSTDP is available to discuss PS with clinicians in other circumstances**
- **The DSTDP always contacts the clinicians before communicating with the patient**

For case investigations and surveillance of reportable diseases, clinicians and health care institutions should know that access by the DSTDP staff to hospital, clinic and laboratory records is specifically authorized under the Massachusetts General Laws (Chapter 111, Sections 53 and 119, and Chapter 111D, Sections 6). Access to medical records is also allowed under the federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 CFR 164.512b). Those regulations state that a covered entity is allowed to disclose protected information to a public health authority (without the written authorization of the individual or opportunity of the individual to agree or object) when it is used for the purpose of preventing or controlling disease, injury or disability. The DIS may need to review records to confirm the patient diagnosis and gather other relevant information.

The tenets of DSTDP PS are as follows:

- The interview for partner elicitation is always voluntary.
- The DIS does not need to know the name of the infected person. (However, if the infected person has only one sexual partner, confidentiality may be compromised.)
- The safety of the infected person is paramount. If there is reason to think that notification of the partner will result in harm to the person, then safety will supercede partner notification.
- Partners are contacted only if the infected person consents.
- Partners are notified of possible exposure, not that they have been infected.
- The source of the information is never revealed or acknowledged.

For more information on PS offered by the DSTDP see *Partner Referral Information*: www.mass.gov/dph/cdc/std/services/parbro.htm

Unfortunately, there are unique challenges related to performing traditional PS for MSM because many men infected with an STD report anonymous sexual partners. Because some men meet their sex partners through the Internet, the only contact information may be an e-mail address. The DSTDP has developed some successful and innovative ways for PS and delivering prevention messages to MSM using the Internet.

For more information on DSTDP Internet initiatives and other states protocols see *State Guide for Working with Manhunt*:
www.ncsddc.org/peer-to-peer_res.htm

The role of the health care provider

For STDs that are "priority cases," it is helpful for the clinician to inform patients that the DSTDP needs to get in touch with them to discuss sexual partners.

For STDs that are not "priority cases," the DSTDP relies on the health care provider to discuss the importance of evaluation and treatment (as appropriate) of partners. In most of these cases, the patient will inform the partner(s) himself (self-referral). Patients infected with chlamydia or gonorrhea should be informed to contact all partners they had sex with within 60 days preceding the diagnosis OR contact the most recent partner if >60 days occurred since last sexual contact. These partners should be evaluated and treated.

For patients with other STDs, such as herpes simplex virus (HSV) or human papilloma virus (HPV), consult the *2002 CDC STD Treatment Guidelines* for partner services guidelines:
www.cdc.gov/mmwr/preview/mmwrhtml/rr5106a1.htm

Clinicians can also choose to contact partners, either verbally or in writing, if the patient consents (a form of provider referral). If specifically requested by the clinician, and with patient consent, the DSTDP can conduct PS.

For more information on partner notification by health care providers see *Partner Notification and Duty to Warn: Separate and Not Equal*:
www.mass.gov/dph/cdc/std/services/stdwar.htm

Key Consent Issue

- **In Massachusetts, partners can be contacted either by the health care provider or the DSTDP only if the patient consents**

Partner counseling and referral services for HIV infection

In addition to providing PS for people with STDs, the DSTDP also performs PS for people infected with HIV; this is commonly referred to as partner counseling and referral services (PCRS). HIV PCRS can be offered to patients with HIV infection as long as contact with DIS is voluntary. The patient does not have to identify himself and may chose whether or not to identify partners after discussion with the DIS. DIS do not have access to medical records related to HIV infection unless they have the consent of the patient.

Discussion about disclosing HIV infection to past and current sexual and injection drug using partners should routinely occur for all HIV-infected people, and be integrated into the larger system of preventive and clinical care. Whereas the central goal of PCRS for STDs is the eradication of infection through treatment, the success of HIV PCRS is evidenced by the prevention of new infections. HIV-infected patients should be informed of the benefits and advantages of PCRS, facilitating informed decision-making about this service.

In Massachusetts, HIV infection is reportable, but not by name. For more information on HIV reporting see *HIV Reporting in Massachusetts – Questions and Answers for Health Care Providers* see:
www.mass.gov/dph/aids/edu_promo/fs_hiv_reporting_provider.htm

Because there is no identifying information on HIV case reports, the DSTDP can only conduct HIV PCRS upon clinician request (by contacting the DSTDP at 617-983-6940) and after patient consent. Providers should note that Mass. Gen. Laws ch. 111 s. 70F explicitly prohibits physicians, health care providers, and health care facilities from "disclos[ing] the results of an (HIV antibody or antigen test) to any person other than the subject thereof without first obtaining the subject's written informed consent." However, the patient can choose to speak with the DIS anonymously through arrangements made by the provider.

For more information about HIV PCRS see *HIV Partner Notification*:
www.mass.gov/dph/cdc/std/services/hivpn.htm

Key HIV PCRS Issues

- **HIV PCRS prevents new infections and refers those infected into care**
- **Massachusetts General Laws prohibits disclosing the results of an HIV antibody or antigen test without first obtaining the subject's written informed consent**
- **Given the option, patients may chose to speak with the DIS and this contact may be facilitated and arranged through the health care provider**

Section 11
Resources & Referrals

General LGBT Resources		
Name	**Phone Number**	**Website**
Gay and Lesbian Medical Association	415-255-4547	www.glma.org
The Health Privacy Project	202-721-5632	www.healthprivacy.org
American Medical Student Association	800-767-2266	www.amsa.org/adv/lgbtpm
National Gay and Lesbian Task Force	617-492-6393	www.thetaskforce.org
The Body: The Complete HIV/AIDS Resource	N/A	www.thebody.com
National Coalition for LGBT Health	202-797-3516	www.lgbthealth.net
National Minority AIDS Council	202-483-6622	www.nmac.org

National Resources		
Name	**Phone Number**	**Website**
CDC	800-331-3435	www.cdc.gov
CDC STD/HIV Hotlines	STD: 800-227-8922 AIDS: 800-342-2437	www.cdc.gov/nchstp/od/hotlines.htm
CDC National Hepatitis Hotline	800-227-8922	www.cdc.gov/ncidod/diseases/hepatitis/index.htm
National Institute on Drug Abuse	301-443-1124	www.nida.nih.gov
Substance Abuse & Mental Health Services Administration	202-619-0257	www.samhsa.gov

Massachusetts LGBT Health Resources		
Name	**Phone Number**	**Website**
Fenway Community Health	617-267-0900 888-242-0900	www.fenwayhealth.org
GLBT Health Access Project	617-988-2605	www.glbthealth.org
GLBT Health Resource Guide	617-988-2605	www.glbthealth.org/resourceguide.html
Massachusetts Health Promotion Clearinghouse	800-952-6637	www.maclearinghouse.com
AIDS Action Committee HIV Hotline	800-235-2331	www.aac.org
AIDS Action Committee Hep C Hotline	888-443-4372	www.aac.org
Massachusetts Substance Abuse Hotline	800-327-5050	www.helpline-online.com

Massachusetts Government Resources		
Name	**Phone Number**	**Website**
Massachusetts Department of Public Health (MDPH)	617-624-6000	www.mass.gov/dph
MDPH Bureau of Communicable Disease Control	617-983-6550	www.mass.gov/dph/cdc/bcdc.htm
MDPH Bureau of Family and Community Health	617-624-6060	www.mass.gov/dph/fch/index.htm
MDPH Bureau of Substance Abuse Services	617-624-5111	www.mass.gov/dph/bsas/bsas.htm
MDPH HIV/AIDS Bureau	617-624-5300	www.mass.gov/dph/aids/hivaids.htm
Boston Public Health Commission	617-534-5395	www.bphc.org

MDPH Sexually Transmitted Disease Clinics		
Name	**Phone Number**	**Website**
Boston Medical Center	617-414-4081	www.bmc.org/medicine/medicine/infectious.html
Massachusetts General Hospital	617-726-2748	www.mgh.harvard.edu/id/mghstd.html
Chelsea Health Center	617-887-4600	www.mgh.harvard.edu/id/mghstd.html
Lowell Community Health Center	978-937-9700	www.lchealth.org
Brockton Hospital	508-584-1200	www.brocktonhospital.com
Stanley Street Treatment & Resources Family Health Center	508-679-5222 x 3228	www.sstar.org/services/fhcc/stdclinic.htm
Planned Parenthood League of Massachusetts - Worcester	508-854-3300	www.pplm.org/clinic/clin_loc/pplm2_3.html
Berkshire Medical Center	413-447-2564	www.berkshirehealthsystems.org/content/info-45-1357-1357.html
Brightwood Health Center	413-794-8354	www.baystatehealth.com/eConsumer/bhs_home.jsp

MDPH Comprehensive Test Sites Providing HIV C&T, viral Hepatitis vaccination and screening, and STD screening and/or referral		
Name	**Phone Number**	**Website**
Fenway Community Health	617-267-0159	www.fenwayhealth.org/services/hiv_serv.htm
Boston Medical Center	617-414-4495	www.bmc.org/medicine/medicine/infectious.html
Cambride Health Allliance	617-591-6767	www.challiance.org/commconn/hiv.htm
Great Brook Valley Health Center	508-854-3260	
Lynn Community Health Center	781-581-3900	www.lchcnet.org/SiteMap/indexhiv.htm
Cape Cod Hospital Infectious Disease Clinical Services	508-862-5650 888-711-0117	www.capecodhealth.org/Services/details.asp?ProgramID=289
Stanley Street Treatment and Resources	508-324-3561	www.sstar.org/services/projectaware/ict.htm

MDPH HIV/AIDS, Hepatitis, STD and Substance Abuse Services and Resources Link		
MDPH HIV/AIDS Bureau	617-624-5300	www.mass.gov/dph/aids/services/hivresourceguide.pdf

Fenway Community Health Resources		
Name	**Phone Number**	**Website**
Fenway Community Health - Main Number and Link	617-267-0900	www.fenwayhealth.org
Primary Care at Health Center including STD Testing	617-927-6000	
Primary Care at South End Associates	617-247-7555	
Research Department	617-927-6450	
Case Management	617-927-6100	
Family and Parenting Services	617-927-6243	
Mental Health and Addiction Services	617-927-6202	
Crystal Meth Support Group	617-927-6202	
Violence Recovery Services	617-927-6250	
Confidential HIV Testing	617-267-0159	
Wellness and Education	617-927-6204	
Living Well	617-927-6450	
Bisexual Health	617-927-6369	
Hotmale - Online Outreach	617-927-6277	
GLBT Helpline	617-267-9001 888-340-4528	
Peer Listening Line	617-267-2535 800-399-PEER (7337)	